MINNESOTA

STATE GOVERNMENT

ISSUES

STRATEGY ON AGING TASK FORCE

COMMUNITY SERVICES

Executive Branch Policy Development Program

1984-1985

STRATEGY ON AGING TASK FORCE

COMMUNITY SERVICES

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In Minnesota, as throughout the United States, the population age 65 and older -- especially persons age 85 and older -- has grown at a much higher rate than expected and is likely to continue to grow at a significantly higher rate than the rest of the population. This population growth is a major force increasing the cost of, and demands on, programs that serve older Minnesotans which are funded by taxpayers and administered by federal, state, and local governments.

In June, 1984, the Strategy on Aging Task Force began, a joint project of the Center for Urban and Regional Affairs and the Hubert H. Humphrey Institute of Public Affairs, both at the University of Minnesota; the Minnesota Department of Finance; and the Minnesota Housing Finance Agency. Under the direction of an interagency task force consisting of representatives from seven state agencies (see Appendix A for a full listing), the goal of the Strategy on Aging Task Force was to explore the impact of the growing elderly population on public programs and expenditures, and to develop coordinated alternatives for long term care utilizing informal networks and community care systems.

In addition, the interagency task force agreed that the study's progress and eventual recommendations should be based on the following assumptions about the direction of state and local policies and programs:

1. The state should ensure that a continuum of services is available for the elderly on a statewide basis.

2. The state should set broad policies for such a continuum while counties or multi-county bodies and public/private arrangements should plan and deliver local services.
3. The state should plan for the increasing aging of the population and decreasing federal support of programs designed to meet the needs of that population.
4. Increasing coordination should occur among all programs serving the elderly at both the state and local level.
5. An aging strategy should focus on specific short term recommendations, but should also set a flexible state direction for the next 15 years.
6. Individuals should rely on themselves and the informal support network before seeking government assistance. Government programs should encourage such reliance.
7. Publicly financed programs should be directed at those most in need and should provide only the needed amount of support in the most effective, least restrictive environment.
8. Existing community based services should be coordinated and utilized before new services are developed.
9. New services should be flexible and focused on a more appropriate use of capital/property investment than current services.
10. The fiscal impact resulting from state initiatives should reflect the appropriate federal, state, and local responsibilities.

The study addressed itself to three major program areas:

1. Income Support Programs
2. Housing
3. Community Services

The research findings and recommendations from each area are contained in separate technical reports and highlighted in the Strategy on Aging Executive Summary. A report entitled "Older Minnesotans: A Demographic Profile" was also produces by the study as a reference resource.

INTRODUCTION

This report is concerned with programs which provide health and social services to older Minnesotans, and the service delivery system which exists in the state. This report will look at programs through which the state provides funds to local goverments and other community service providers through its Departments of Economic Security, Energy and Economic Development, Health, Human Services, Transportation, and Veterans Affairs. Special attention is given to the programs of Human Services and Health.

The goal of this portion of the Strategy on Aging is to evaluate the strengths and weaknesses of the community services system, to recommend changes that will meaningfully build on those strengths, and, where appropriate, to fill in any recognizable gaps. The tasks of this portion of the study included original research, review of other recent reports, and consultation with appropriate program staff.

There are three major sections to this report. The first section -- Overview of Community Services -- provides background on Minnesota programs giving care or assistance to older persons, summarizes the state's statutory and regulatory requirements of local agencies, and reviews demographics of the elderly and their significance to community services.

This section focuses on the following questions:

1. What programs are there in the state that are serving older people? In what ways are these programs complementary, duplicative, or in conflict?

2. What are the kinds and amounts of services being provided by these programs? How many people are being served? Are there gaps in services?
3. What are the roles of the state, local government, and service providers in coordinating, planning, and evaluating the programs that attempt to meet the needs of elderly community members?
4. Most importantly, what incentives do these programs create for individuals and local governments with respect to the utilization of institutional and/or noninstitutional service providers?

The second section provides an analysis of the community services system using the issues that underly the study's assumptions. These policy setting issues are: program and fiscal incentives; state policy setting/local planning and delivery; the continuum of care; coordination and case management; reinforcing the informal support system; and service targeting. This analysis highlights additional steps the state might take in concert with counties to further develop alternative long term care services.

Clarifying and strengthening the roles and responsibilities of state and local governments will aid the efforts of not only public and private service providers, but also of the informal support system of families, friends, and neighbors -- which provides as much as 90% of the care needed by older Minnesotans.

The final section pulls together the analysis of the first two sections into the recommendations of the study. The recommendations

are meant to strengthen the capacity and incentives for counties to develop or expand and fund community services that will help prevent or postpone institutional placement of older people, helping them to enjoy a higher quality of life with maximum independence.

I. OVERVIEW OF COMMUNITY SERVICES

Minnesota currently provides a wide array of human services to its elderly population. These services are coordinated by eleven state agencies, and are primarily delivered directly by county agencies, or through contracts with private and nonprofit agencies. While the vast majority of public expenditures on behalf of older Minnesotans go toward institutional nursing care, there has been considerable interest by both the executive and legislative branches of state government in developing community services that offer alternatives to nursing homes and other institutions.

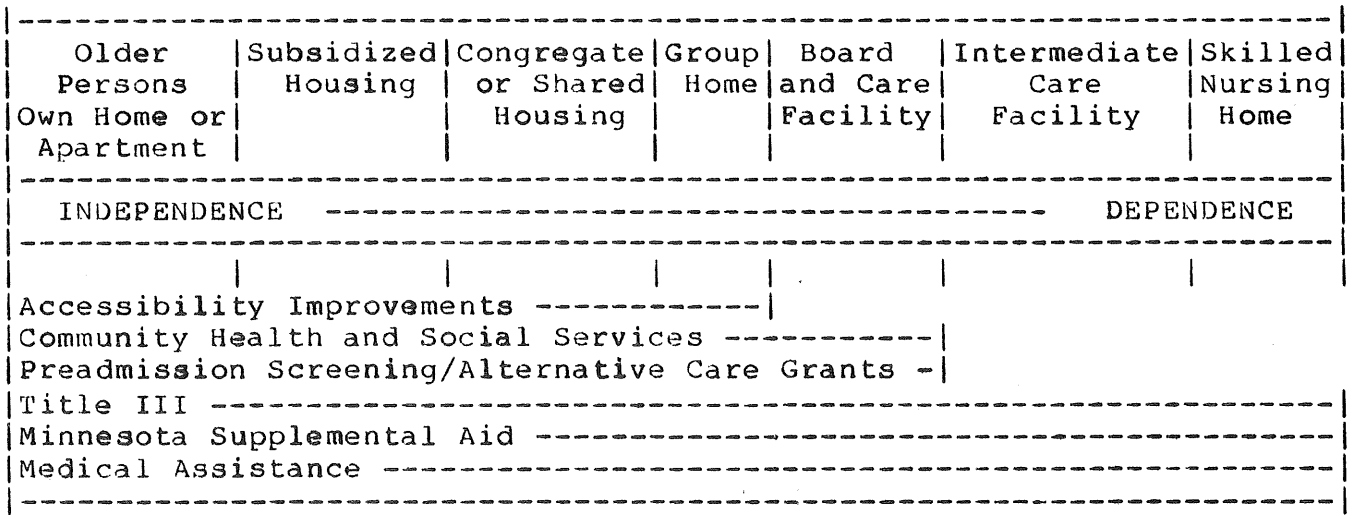
This report addresses the community services programs that involve the Minnesota Departments of Economic Security, Energy and Economic Development, Health, Human Services, Transportation, and Veterans Affairs. After a brief summary of each of these programs and the state's laws and regulations relating to them, they will be compared and evaluated using the goals and assumptions of the task force.

A. COMMUNITY SERVICE PROGRAMS

The community services portion of the Aging Strategy Study focuses on eleven state supervised programs which fund part of locally delivered community health and social services. These programs are the most important programs providing noninstitutional services for long term care in which the state has a significant role and interest, and they constitute a significant portion of the continuum of care available in the state.

The full continuum of care can be described as the range of care or assistance which individuals need to live meaningful and comfortable lives. This ranges from the person who has the ability and resources to arrange, manage, and pay for services she/he needs, but who may need information and referral, to the person needing only a few public services such as transportation, nutrition, and an occasional homemaker, to the person needing considerable care and attention in a highly skilled nursing home. Figure 1. shows the continuum of care.

Figure 1. THE CONTINUUM OF CARE



The descriptions below include estimates of expenditures and persons served for the most recent year available. Added together, these programs involve over $1.6 billion, including over $500 million

in state funds. (See Appendix B. for a more detailed description of these community service programs.)

MINNESOTA DEPARTMENT OF ECONOMIC SECURITY.

Community Services Block Grants (CSBG) provide over $6 million in state (Minnesota Equal Opportunity Grants -- MEOG) and federal (CSBG) funds to support planning and administration by 27 Community Action Agencies and eleven Indian Tribal Communities in the state, advocating and providing programs in the interests of low income Minnesotans (see Figure 1).

Energy Assistance assists low income households (60 percent or less of the state median income) in meeting the cost of home energy, and reducing current and future energy expenditures. Over $82 million in federal funds will serve about 43,000 elderly households out of a total of 139,000 households in the state this year.

Weatherization provides over $20 million for one-time home improvements to reduce energy consumption and ensure safety for households with 125% or less of poverty income. 11 percent of households served included an elderly member in 1983, about 1900 households out of a total of 17,000. Elderly households have received a large share of these improvements -- about 35 percent of households served when the program began in 1980, declining to about 11 percent in recent years.

MINNESOTA DEPARTMENT OF ENERGY AND ECONOMIC DEVELOPMENT.

Community Development Block Grants (CDBG) provide nearly $23 million in state and federal funds for housing, economic development, public improvements, and (up to 15 percent for) public services, for which low and moderate income person are targeted as the major beneficiaries.

MINNESOTA DEPARTMENT OF HEALTH.

Community Health Services Block Grant (CHS) provides nearly $20 million in state and federal funds in conjunction with over $55 million in local funds and fees, for health services including home health and public health nursing, provided by 47 local health boards for all Minnesotans (except Pine County which does not participate in CHS). 26,025 elderly were served by public health nurses in 1982, constituting 36 percent of all clients, and receiving 53 percent of all nursing visits.

MINNESOTA DEPARTMENT OF HUMAN SERVICES.

Community Social Services Block Grant (CSSA) provides about $100 million in state and federal funds in conjunction with over $100 million in local funds and fees, for social services provided by 83 county social service agencies, targeted to groups including vulnerable adults and elderly experiencing difficulty living independently. Individual eligibility is usually based on categorical eligibility for AFDC, GA, SSI, MSA, etc., 60 percent of the state median income, or sliding scale for most services;

other services are often provided to all needy persons. A duplicated count of 72,000 elderly Minnesotans were served in 1982.

Medical Assistance (MA or Medicaid) reimburses nearly $950 million in state and federal funds to providers for medical services to low income individuals, including the elderly. About 60 percent of all MA funds go to institutional long term care services, with less than one percent going to alternative home care services. Covered in-home services include personal care, nursing, home health aides, and some supplies and equipment. 52,819 elderly were among those enrolled in the MA program in state fiscal year 1983 (13.2 percent of the total).

Preadmission Screening/Alternative Care Grants (PAS/ACG) provide over $10 million in state and federal funds to county social service agencies for homemaker, respite care, personal care, foster care, adult day care, home health aide, and case management services to prevent or postpone institutionalization. The program is funded through a federal Medicaid waiver, and a corresponding state funded program for individuals who would be eligible for MA within six months after they entered a nursing home.

Title III of the Older Americans Act provides over $15 million in state and federal funds in conjunction with over $8 million in local funds and fees, for nutrition and social services for all persons age 60 or over, targeted to those most in need.

MINNESOTA DEPARTMENT OF TRANSPORTATION.

Mass Transit, and Special Programs for the Elderly and Handicapped provide over $47 million in state and federal funds, in conjunction with over $76 million in local funds and fees, for operating transit programs for all Minnesotans, and for categorical programs for elderly and handicapped (nearly $6 million of the total). $3 million of the total is available for capital purchases. 70 percent of nonmetro ridership is estimated to be elderly.

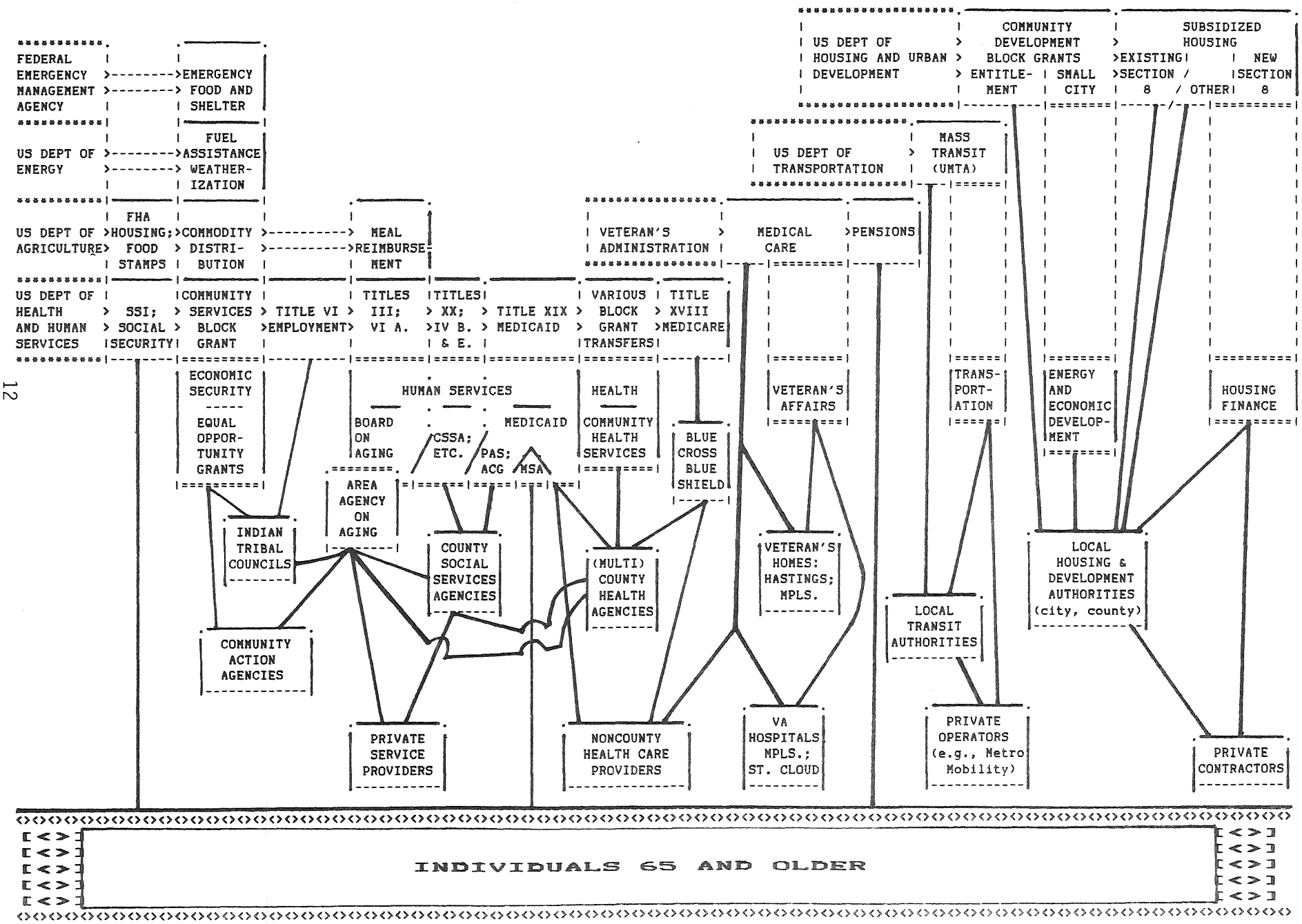
MINNESOTA DEPARTMENT OF VETERANS AFFAIRS.

Veterans Homes provide over $8 million for health and domiciliary care to veterans, their spouses, and parents.

These programs constitute the publicly supported long term care system in Minnesota. Programs may be narrow in purpose, such as transit, giving local governments less discretion about the use of state and federal funds, or very broad in purpose, such as the Community Social Services Act (CSSA), which allows counties to provide as few as eight or as many as 49 different community social, health, housing, and nutrition programs. Older Minnesotans receive care and assistance through all of these programs.

Services funded under these programs show considerable overlap and duplication. Table 1. shows the number of older persons receiving selected services funded by six programs. Before discussing the advantages or disadvantages of the current system, it is necessary to

FIGURE 2. COMMUNITY SERVICES SYSTEM FOR SERVICES TO THE ELDERLY



services for older Minnesotans are all under the jurisdiction of county boards; some Title III funds go to county agencies, as well as to community action agencies and private providers.

Older Minnesotans needing help face a complex service delivery system; there is no single agency that is considered to be primarily responsible for responding to an older person in need of assistance. Figure 2. shows the array of federal, state, and local agencies and programs available to help older people in Minnesota, a system which may be quite bewildering to those it is meant to help. An older person may negotiate the system by successfully enlisting the aid of a referral agency or case worker, or may be able to find a single agency offering the needed services. Often this complexity will lead to confusion, frustration, and perhaps resignation, because the agency contacted by an older person doesn't know what is available through other agencies, and doesn't know to whom they can refer the older person. Without a lead agency or agencies, it is unlikely that people needing help will be aware of who is best able to help.

Besides program administration and service delivery, the other important state requirements for local agencies are planning and reporting. Of the eleven programs outlined above, only four require plans to be submitted by local agencies: CHS, CSSA, PAS/ACG, and Title III. Other than financial reporting, and excluding Medicaid, there is no standard reporting of program activity which allows for direct comparison or evaluation of programs within a county or region. Medical Assistance has a state operated client-based infomation system to which providers report services and payments by client Medicaid eligibility number. CSSA is now using a client based Community

Services Information System (CSIS) which should provide detailed data by county for 1983 (to be completed in late 1984) such as is now available for MA. CHS is also implementing a standardized reporting system for local health boards.

A 1984 report by the Legislative Auditor noted that it was not possible to effectively evaluate the success or failure of CHS or CSSA using information currently compiled by local governments for state agencies. Planning requirements for CHS and CSSA also lack standardization for comparison or evaluation.

Statutes and regulations generally require coordination in planning and service provision by local agencies, yet most plans and reports lack any demonstrated systematic determination of local needs for community services, a description of local public and private efforts to meet those needs, and the strategies to allocate private and public resources to pay for needed services. Usually the agency responsible for the plan or report deals only with the services under its jurisdiction for which it intends to pay, ignoring other competing service providers. Determination of the need for services is often not based on any standard measures, such as state or Census Bureau demographics, or surveys to determine rates of impairment or needs perceived by the population.

(See Appendix C for more detail on programs and agencies.)

C. DEMOGRAPHIC TRENDS

While Minnesota's nonelderly population will grow by 603,031 persons (a 17.7 percent increase) between 1970 and the year 2000, Minnesota's elderly population will grow by 192,702 (a 47.3 percent increase). At the same time, Minnesota's frail elderly will grow by 58,703 -- an increase of 183 percent. The substantial increase in numbers of Minnesotans age 85+ is directly related to increased longevity, and to a much lesser extent, migration of elderly to the state. Increased longevity is related to improved and expanded health care and social programs, and to reduced poverty. Table 2 provides greater detail about the growth and change in the numbe of elderly and nonelderly Minnesotans.

Table 2. TOTAL POPULATION BY DECADE, 1970 TO 2010

	1970	1980	1990	2000	2010
Young Elderly (65-74)	240,406	270,148	295,969	292,412	343,268
Older Elderly (75-84)	134,773	156,627	184,422	216,766	219,630
Frail Elderly (85+)	32,078	52,789	68,542	90,781	112,472
All Elderly	407,257	479,564	548,933	599,959	675,370
Nonelderly	3,397,407	3,596,407	3,822,046	4,000,438	4,080,564
All Minnesotans	3,804,664	4,075,971	4,370,979	4,600,397	4,755,934

Source: Minnesota State Demographer

While Minnesota's nonelderly population will grow at an average rate of 5 percent per decade from 1980 through the year 2000, the number of people age 65 and older will grow at an average rate of 14 percent per decade; the number of persons 85 and older will grow at an average of 38 percent per decade during the same period. The elderly

population will grow three times as fast as the nonelderly population. The number of Minnesotans age 85 and older will grow eight times as fast as the nonelderly population. Table 3 provides greater detail about relative population growth and change in Minnesota.

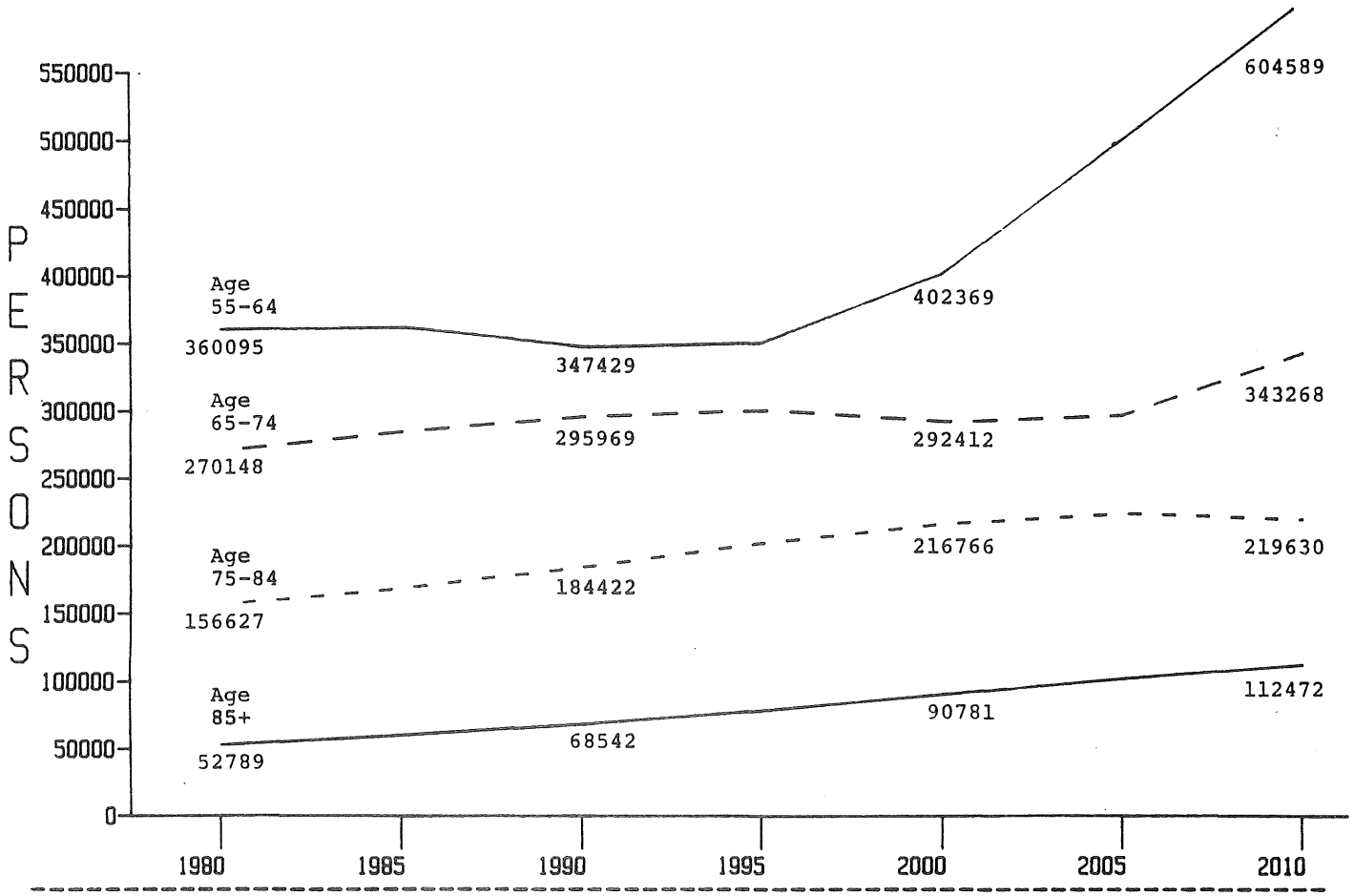
Table 3. PERCENT GROWTH IN POPULATION PER DECADE

	1970	1980	1990	2000	Average
Nonelderly (<65)	5.86%	6.27%	4.67%	2.00%	4.70%
Elderly (65+)	17.75%	14.47%	9.30%	12.57%	13.52%
Frail Elderly (85+)	64.56%	29.84%	32.45%	23.89%	37.69%
Minnesota	7.13%	7.24%	5.25%	3.38%	5.75%

Source: Minnesota State Demographer

Figure 3. shows the growth among groups of older Minnesotans as projected by the state demographer from 1980 to 2010. Persons age 85 and over are the only group expected to continue to grow through this period. The other groups show decreases in numbers at different points in this period, though considerable increases are expected for all groups by the year 2025, as indicated by the steep upswing in numbers of persons age 55 to 64 after the year 2000.

Figure 3. MINNESOTA POPULATION GROWTH, 1980 TO 2010



Source: Minnesota State Demographer

An increasing population of older Minnesotans is likely to mean some increase in need and demand for community services. The size of this increase is unclear and debatable, given the complexities of the community services system. One way to understand a part of this complexity is in a December, 1983, report by the State Demographer's Office which showed that population growth during the 1970s accounted for most of the growth in nursing home beds, with only a slightly greater rate of utilization.

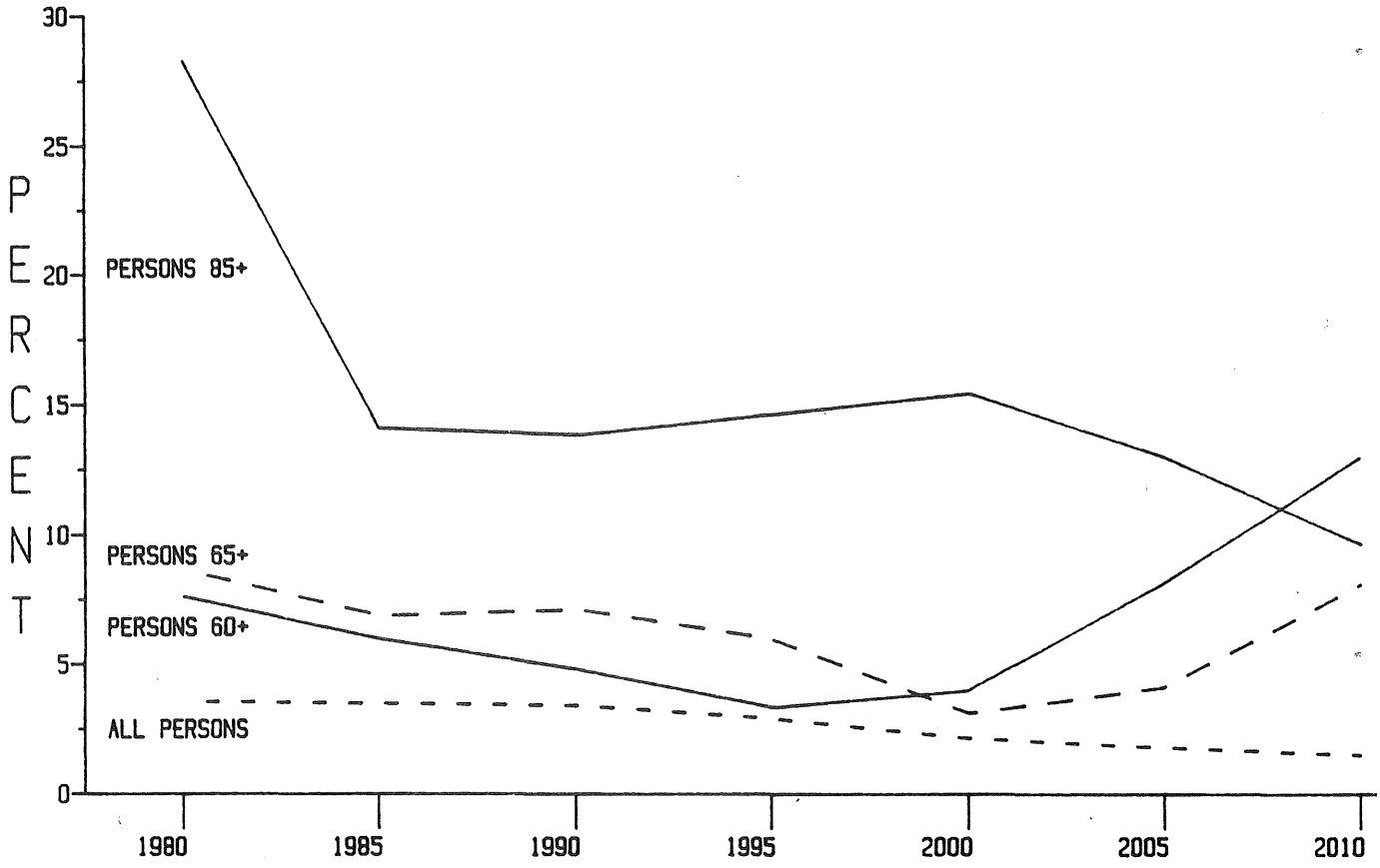
Increases in nursing home population are underscored by census

data showing a 31 percent increase in persons living in institutions, while the elderly population grew only 17 percent. However, the population of persons age 85+ grew by over 56 percent; the growth in institutional population is mostly attributable to the growth in this age group. Larger numbers of elderly will surely mean increasing demands on nursing homes if other alternatives are not available. The Department of Human Services estimates that 1200 additional elderly per year will need nursing home services between 1985 and 1990.

Another way to look at how population changes affect demands for services is to see how groups of persons eligible for community services have grown and are expected to grow through the next century. Figure 4. shows the increase in the number of persons age 60 and over who are categorically eligible for Title III services. Many counties provide services to those 65 and over on a categorical basis as well, though some use sliding fee scales for at least some services. Persons 85 and over, who have the highest needs for care and assistance, will increase by 30 percent during each of the next two decades.

The final issue to note is the considerably higher rate of growth for older Minnesotans, as compared with nonelderly Minnesotans. If need and demand for services to the elderly grow at a higher rate than the growth in the general population, what can be done to ensure that services will be available to those willing and able to pay for them, and for others who may not be able to pay? This issue is addressed in the next section.

Figure 4. MINNESOTA 5-YEAR POPULATION GROWTH RATES



Source: Minnesota State Demographer

II. ANALYSIS OF THE COMMUNITY SERVICES SYSTEM

This section will compare the current community services system against the ideal characteristics of such a system. These characteristics follow directly from the interagency task force's goal and assumptions listed in the forward. After a brief overview, these characteristics will be discussed in the following order: program and fiscal incentives; the continuum of care; state policy setting, local planning and delivery; coordination and case management; reinforcing the informal support system; and service targeting.

A. Overview

The basic purpose of the community services system is to help those who are experiencing difficulty in their lives, whatever the source of the problem. The basic question is how well does this system, or a modified system, care for the people we wish to help.

The community services system is a complex array of services and programs which are the responsibility of the state and many local agencies. The analysis below focuses on the characteristics of this system and the effect it has on the ability of individuals to find and receive the help they need. Furthermore, these characteristics may cause the community services to develop in certain directions which are less desired by clients, providers, and policy makers alike, with respect to the continuum of services available, the cost of those services, and the ability of those who manage the system to make the most of public and private resources available.

These characteristics make up the issues faced by state and local

policy makers who provide services to clients, and who plan and report to state government on their activities. Analysis of these characteristics will follow from the broader issues, with a discussion of the merits and problems of the current system, and alternatives or modifications to the system.

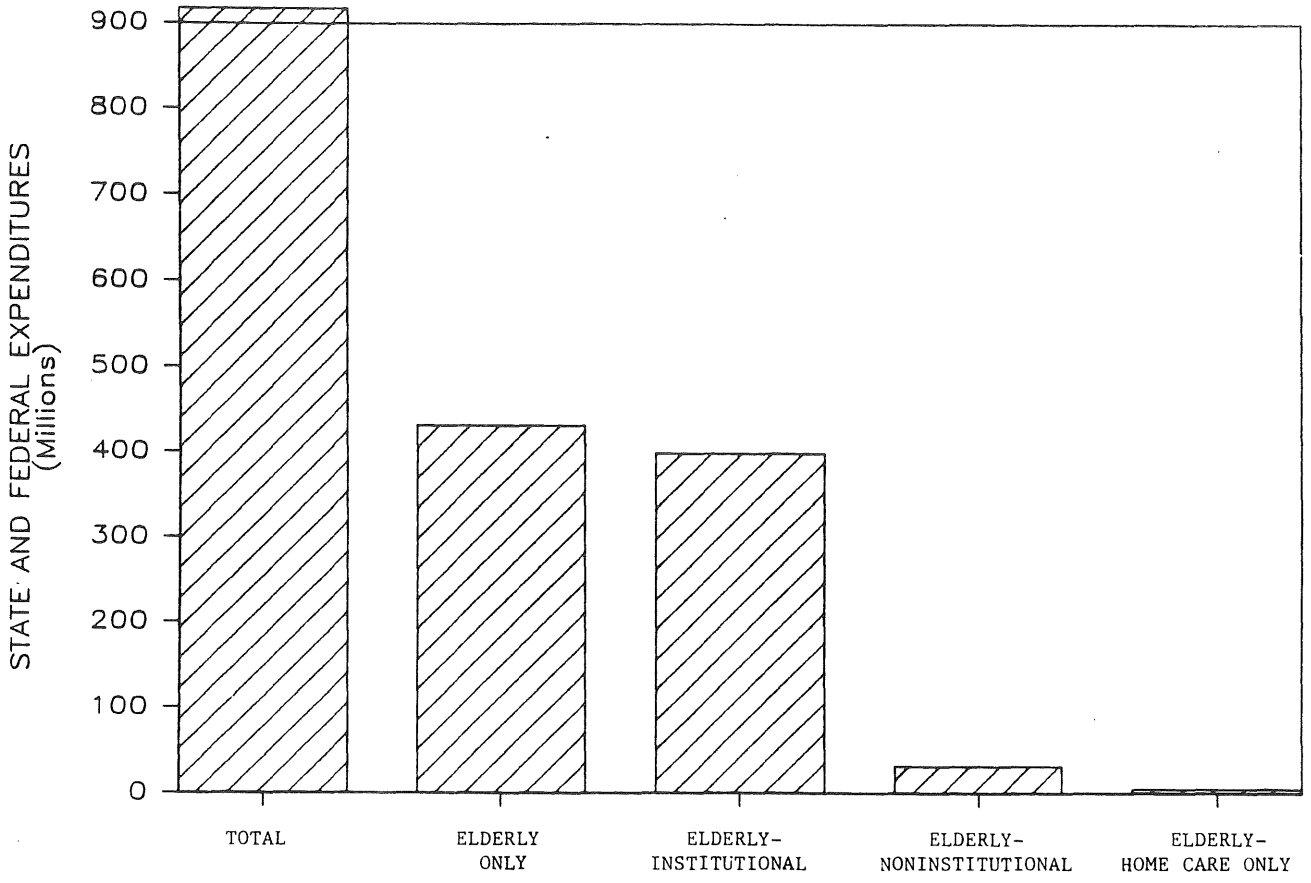
B. Program and Fiscal Incentives

The Minnesota Strategy on Aging is focused on the need for greater utilization of noninstitutional community services by counties in order to contain program costs, and to develop, expand, and provide older Minnesotans with alternatives to institutional placement. The service system should make the best use of the continuum of care, and ensure the development of programs and services to fill existing gaps in that continuum. The state should create incentives for counties which favor noninstitutional programs when more effective and/or less expensive than institutional placement and programs.

A 1984 report by the Citizens League stated that "[t]he 'problem' in [this] system is that people can only receive 'service' if they live in a residential facility." If nursing homes are the only place which offer enough services to impaired individuals, then nursing homes will naturally be highly utilized. If a distinction is made between the "care" and "housing" costs, the Citizens League believes less expensive alternatives can be readily developed. Providing services to persons in their own home, such as is done through the Preadmission Screening/Alternative Care Grants Program (PAS/ACG), can reduce incentives for institutional placement.

However, Medical Assistance (MA) does not distinguish between care costs and housing costs for institutional placements, and is considered by many to be the program that drives the long term care system. Counties may face fiscal incentives to place persons needing significant health and social services in nursing homes and other institutions, as relatively little funding is available for home care. Figure 5. shows this incentive graphically; only one percent of all MA funds go to home care.

FIGURE 5. MA PROGRAM EXPENDITURES, BY PURPOSE, ESTIMATED FOR SFY84



While counties pay less than 5 percent of all costs for institutional care under the MA program, counties are required to match state appropriations for noninstitutional community services under CHS and CSSA dollar for dollar; they are in fact paying over 50 percent of all such community service costs. (See program summaries in Appendix B.) It is important for the state to consider what incentives counties actually have, and what changes may provide more favorable incentives for programs and services which are less costly than institutional care, and for guiding counties in the development or expansion of such programs.

One indicator of the magnitude of fiscal incentives is the relative availability of public funding for noninstitutional versus institutional programs which provide services to older Minnesotans. Table 4. shows the total state and federal funds estimated to have been spent for five programs in state fiscal year 1984, and the share of the funds which went to institutional care, and home care. Figure 6. shows the relative size of the funding for these programs in addition to weatherization, energy assistance, and Minnesota Supplemental Aid, and the proportion made available to elderly persons living at home during the same period. Of all public funding which benefits the elderly, $399 million (about 82 percent) was spent on institutional care, while less than $25 million was spent on home care.

In order to achieve a greater balance between institutional and noninstitutional community services, the state passed a nursing home bed certification moratorium in 1983. The nursing home moratorium effectively caps the medical assistance-funded beds available in

Table 4. SUMMARY OF LONG TERM CARE PROGRAMS

MEDICAL ASSISTANCE pays providers for medical services to low income persons. Counties pay 10 percent of the nonfederal share.

	Fiscal Year 1984 Expenditures		
	Federal	State	Total*
All Services	$482.2M	$418.5M	$900.7M
ELDERLY -- All Services	229.3M	201.9M	431.2M
Nursing Home Services	212.2M	186.9M	399.1M
Noninstitutional Services	17.1M	15.0M	32.1M
Home Care Services only	2.6M	2.3M	4.9M

PREADMISSION SCREENING/ALTERNATIVE CARE GRANTS screens people age 65+ considered at risk of entering a nursing home, and pays providers of long term care home services to prevent or postpone nursing home placement. Counties pay 10 percent of the nonfederal share.

	Fiscal Year 1984 Expenditures		
	Federal	State	Total*
All Services	$ 0.8M	$ 3.9M	$ 4.7M
MA Eligible Home Services	0.8M	0.7M	1.5M
Non-MA Eligible Home Services	--	2.8M	2.8M

COMMUNITY SOCIAL SERVICES (CSSA) BLOCK GRANT pays for a variety of services delivered by county social services agencies. Counties allocated $133 million in for CSSA addition to the figures below.

	Fiscal Year 1984 Expenditures		
	Federal	State	Total*
All Services	$ 42.2M	$ 57.7M	$99.9M
ELDERLY -- All Services			9.3M
Home Care Services only			0.9M

COMMUNITY HEALTH SERVICES (CHS) BLOCK GRANT pays for a variety of services delivered by Local Health Boards. Counties allocated $64 million for this program in addition to the figures shown below.

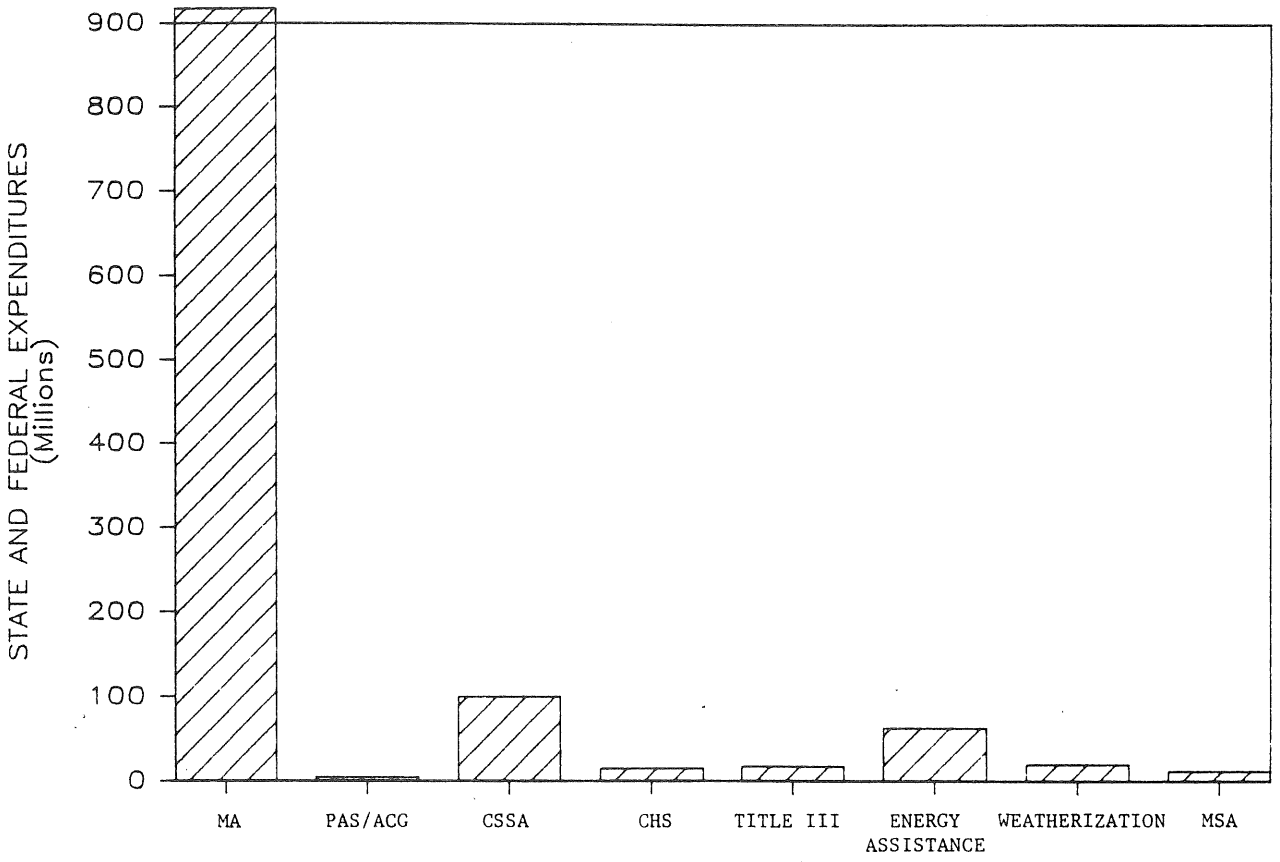
	Fiscal Year 1984 Expenditures		
	Federal	State	Total*
All Services	$ 6.6M	$ 11.2M	$17.8M
ELDERLY -- Public Health Nursing			not available

TITLE III (OLDER AMERICANS ACT) GRANTS pay for a variety of social, health and nutrition programs for persons age 60+, contracted by regional Area Agencies on Aging.

	Fiscal Year 1984 Expenditures		
	Federal	State	Total*
All Services (elderly only)	$ 11.6M	$ 3.5M	$15.1M
Home Care Services only			13.8M

* Total excludes county funds (see Appendix B for more detail).

FIGURE 6. PROGRAMS SERVING OLDER MINNESOTANS, SFY84 FUNDING LEVELS



nursing homes at 46,597. Minnesota currently ranks third in the nation in nursing home placements, with about 9.3 percent of its older population in nursing homes. This high ranking suggests that the counties will probably be able to reduce their rate of institutional placement as alternative care programs are more fully developed.

As the PAS/ACG program is implemented more fully throughout the state, it is expected to fill a substantial part of the gap in

community services that most counties were unable to fill themselves. Through this program, counties receive funds for services including adult day care and foster care, case management, homemaker, home health aide, personal and respite care. Case management enables a county worker to develop a care plan for each individual, utilizing her/his personal resources (including the informal support system) and the most effective, least costly services available locally.

Counties pay the same share of costs for MA eligible persons for PAS/ACG as for institutional placement, about 5 percent. For persons who would be eligible for MA within six months of entering a nursing home, the county pays 10 percent of the costs. Services for other persons who may be less needy and are not considered at risk of entering a nursing home, are funded under CSSA, CHS, and Title III as described above.

C. State Policy Setting, Local Planning and Delivery

As demonstrated above in Figure 2., the community service system for older people is fragmented; no single agency has the power or responsibility for pulling together the different segments into a coordinated system. For clients, this means that access to services is difficult and confusing. While many agencies may be able to provide the services, no single agency is held responsible for the effectiveness or appropriateness of care given. For counties, this means that they will be in competition, and perhaps in conflict with other agencies, such as private providers, charities, and area agencies on aging (which contract with local providers independently of counties). For clients, providers, policy makers, and taxpayers

alike, it means higher costs due to a lack of coordination, excessive overlap and duplication, and higher administrative costs.

The state of Minnesota may give as much power and responsibility to counties under these programs as any other state in the country, especially through its use of block grants. The discretion counties are given through these block grants results in the overlap shown in Table 1. The state has relied on the use of mandatory target groups to ensure that vulnerable and needy families and individuals may receive some kind of service. The state cannot assure individuals that the services which would be the most helpful to them will be available in the county in which they reside.

The development of statewide goals for CSSA and CHS have received regular attention and debate. In fact, Minnesota county social services agency directors are currently working on the development of such goals.

In his report on state block grants, the Legislative Auditor found one weakness in CHS and CSSA block grants to be the lack of statewide goals for specific policies such as expanding the development and use of noninstitutional long term care services. The development of goals that address the appropriate roles of local agencies could result in greater coordination and less duplication, and could better ensure that older Minnesotans have access to services which can help to prevent or postpone institutionalization. To require that counties implement policies which can measurably meet statewide goals would require a change in state law, and result in a loss in discretion for counties.

State planning requirements call for a two-year Local Health Board plan for CHS, to be submitted in odd numbered years, and a two-year county plan for CSSA, to be submitted in even numbered years. Having these planning efforts on different schedules can only make local coordination more difficult. Nonetheless, some counties may prefer to make plans in different years in order to spread out the tasks of their planning staff over the two years.

Another important issue related to the timing of these plans is the usefulness of CSSA planning when it is based in part on only six months of state appropriations. This occurs because final two-year CSSA plans are required to be submitted 18 months after the state's biennial budget is passed. CSSA planning is closely related to county budgeting, and counties rely heavily on state funds to pay for a part of local social services. If CSSA planning were timed to give counties 18 months of the biennial budget from which to plan, the CSSA process as well as the plans would be more useful to local policy makers, service providers, and community members.

Other state programs which require local plans, such as PAS/ACG, should be considered for integration into CSSA or CHS as part of a consolidation of planning efforts.

The state created Human Service Boards in statute in 1973 to aid the efforts of local government to consolidate its community services programs under one single-county or multi-county agency, requiring a single annual plan for all programs. According to the statute, this plan is to be used to meet all state program planning requirements. However, none of the programs requiring plans have promulgated rules

which would make these plans officially acceptable. Because of this and other state requirements, Human Service Boards are effectively the most burdensome organizational structure available to counties for community services. Only seven Human Services Boards have been created by 10 counties in the state. (See Appendix C. or Minnesota Statutes Chapter 402 for more details.)

Table 1. shows how Title III funds are allocated by Area Agencies on Aging for services provided to older Minnesotans; this allocation constitutes considerable duplication of effort. The State may choose not to allow this overlap to continue in order to make the best use of its limited resources, and to ensure the development of a more coordinated community services system. It is beyond the scope of this study to come to a conclusive recommendation on how the State can best utilize Title III funding, and the appropriate role of Area Agencies on Aging and the Board on Aging. The State can select from among the following options:

(A) Require that all Older Americans Act funds, except for Indian Tribal Communities and legal and advocacy services, be given directly to counties who will provide or purchase these services for older Minnesotans along with CSSA, Title XX, and other services. Counties would receive Title III funds for nutrition and social services, and would coordinate these services with all other fund sources. Transfer the majority of responsibility and funding for program development and administration of Title III services to counties. The Board on Aging and Area Agencies on Aging would retain their vital role in advising state and local agencies and advocating for the interests of older Minnesotans.

Programs including advocacy, legal services, and ombudsmen would be retained by the Board and Area Agencies.

(B) Abolish regional Area Agencies and establish Area Agencies in each county, or through multi-county joint powers agreements, such as currently exists for the Region Four Area Agency on Aging.

(C) Implement option A for only those counties which request to provide Title III services as outlined above; continue Area Agency responsibility in other counties.

(D) Study further the role of the Board on Aging and regional Area Agencies on Aging in the community services system to determine what changes, if any, will make more effective use of Title III funds and programs, especially with respect to long term care.

A number of facts and issues are important in the consideration of which option to pursue. As outlined below, they are related to: (1) administrative efficiency; (2) coordination, planning and program development; (3) service targeting; (4) access; (5) separation of advocacy and service provision; and (6) the need for a single independent state agency to advocate on behalf of those needing long term care.

(1) Board on Aging and Area Agency on Aging administration and program development costs were 14 percent of all federal and state funds ($1.8 million of $12.9 million) for Title III programs in 1983. Could counties provide comparable administration and program development at a lesser cost?

(2) As shown in Table 5, $347.9 million was estimated to have been spent in 1984 by local agencies for locally controlled programs which fund home care services. 92 percent of the funds available are under the control of counties; Area Agencies have only $25.5 million of the total. Minnesota Statutes 256.01 Subd.8 provides that County Boards "may designate a county services coordinator who shall coordinate services and activities, both public and private, that may further the well being of the aging and meet their social, psychological, physical and economic needs. The coordinator shall perform such other duties as the [County Welfare Board] may direct to stimulate, demonstrate, initiate, and coordinate local public, private, and volunteer services within the county dedicated to providing the maximum opportunities for self help, independence, and productivity of individuals concerned." Can counties do a better job of planning, developing, and coordinating programs with control over Title III funds along with their current programs? Are there differences among Area Agencies that make this more or less likely to occur?

Table 5. TOTAL EXPENDITURES BY RESPONSIBLE AGENCY IN 1984 (estimated)

	Area Agencies	Counties
Title III	$25.5M	
PAS/ACG		$ 8.0M
CHS		81.6M
CSSA		232.6M
Total	$25.5M	$322.4M

(3) Federal law requires that Title III programs be targeted to elderly who are economically or socially needy; federal law also prohibits the use of needs tests for Title III services.

Eligibility is categorical for all persons age 60 and older, and not based on ability to pay. Given that the Strategy on Aging recommends that counties be given responsibility to assess the needs of elderly and develop care plans, will county case managers be in a better position to ensure that Title III services are targeted toward those in greater need?

(4) Related to targeting is access; access is not only dependent upon the knowledge of service providers, care givers, and persons needing help, but the advertising and outreach efforts of service agencies, and the availability of transportation services, especially in rural areas of the state. If county social service agencies are designated as the lead agency for local services to the elderly, would they be best able to ensure access to services for those in need?

(5) To some degree there is always a conflict of interest within an agency between its role as advocate, and its role as service provider. This conflict is sometimes reduced by contracting for all services, or contracting for advocacy. For Area Agencies, it is also reduced by federal law which prohibits them from providing direct social services except for information and referral, advocacy, program development and coordination, individual needs assessment, and case management. Area Agencies must contract with private or public providers for any other services which they wish to fund. Similarly, there is a conflict in agencies between the development of appropriate care plans for clients, and the need to ensure that there are sufficient clients

to justify continued funding. To what extent does separation of these roles ensure more humane, effective, and affordable care for persons who need the help of public programs?

(6) The State's 1981 Long Term Care Plan recommended the creation of an independent agency which would advocate in the interests of those who need long term care services. Among the powers of this agency would be to propose legislation; review and comment upon proposed legislation and policies of state agencies; and pursue research and demonstration projects in areas related to long term care. If the Board on Aging's role in the state is to focus on advocacy, could it not also take on these other tasks which closely resemble the Board's powers and responsibilities with respect to older Minnesotans?

D. The Continuum of Care

The ideal continuum of care should include an array of services which are determined by local agencies to be most effective and least costly. The continuum described in the above program summaries and Table 1. shows the array of services that constitute the continuum of care. Table 6. is a representation of the continuum of care available in Minnesota.

Table 6. CONTINUUM OF CARE, LONG TERM CARE SERVICES

Acute Care Hospitals:	168 Community Hospitals:	20,752 beds
	6 State Hospitals:	1,911 beds
	4 Federal VA Hospitals:	1,215 beds
Sub-Acute Care:	1 Metropolitan facility:	200 beds
	4 Federal VA Hospitals:	170 beds
Institutional Care:	442 Nursing Homes:	43,561 beds
	111 Boarding Care Homes:	4,946 beds
	7 State and Federal VA Facilities:	1,950 beds
Community Care:	101 Certified Home Health providers; and hundreds of private and nonprofit agencies, institutions, and individuals providing services including: Adult Day Care; Case Management; Service Coordination; Congregate/Home-delivered Meals; Transportation; Respite Care; Chore/Homemaker; Home-health Aide, Home Nursing, Social Services, and Legal/Financial Services	
Informal Care:	Family, Friends, Neighbors, Churches/Parishes, Community/Volunteer Groups	

Adapted from: Final Report: Interagency Task Force on Long Term Care Services for Veterans, page 25.

There was a considerable gap in the continuum of care for those less able to pay for the services they needed before the PAS/ACG program was begun. There may still be a significant gap in the availability or effectiveness of noninstitutional long term care services. Because the state made a significant commitment to funding institutional care, it was limited in its ability to fund other community alternatives. The nursing home moratorium, and the growing number of elderly require the state to ensure that alternatives to institutionalization are available for those who are able and willing to pay for alternative services, and for those unable to pay.

The state should ensure that older people have the opportunity to exercise their free choice to purchase the services they need, remaining independent from the public services system. Medical and institutional services are widely available, along with medical transportation. Social services are unevenly available statewide, including nonmedical transportation. Social services, especially in rural areas, are often not offered privately because it is simply not economically feasible to do so. It may be that some or all of the services desired by an individual are not available locally.

The development of alternative home care services has often depended on public funding; without purchase of service contracts or reimbursements for providing services to public program clients, many service agencies would not be economically viable. High transportation costs and low population density add to the cost of providing services in rural areas. The problem of service availablitity may be made more difficult because of the discretion given counties and other local agencies by the state through its use of block grants. A change in state law would be required to mandate the availablity of services locally; this issue is sensitive and complicated by both the nature of state block grants, and the expense of maintaining local service availability.

To understand how PAS/ACG has filled a gap in the continuum, it is necessary to distinguish between the MA portion of the program and the 180-day portion. The MA waiver is awarded by the federal government on a three year basis, and is up for renewal in 1985; the state has relatively little discretion in the program since federal funds are accompanied by federal rules and restrictions. The 180-day

program is wholely funded by the state and counties, and the state has considerable discretion over how this program is structured. PAS/ACG services go to those who meet the income and assets test for MA, and those who would become eligible for MA within 180 days of entering a nursing home. During fiscal year '84, only 27 percent of those provided alternative care grant services were eligible for MA.

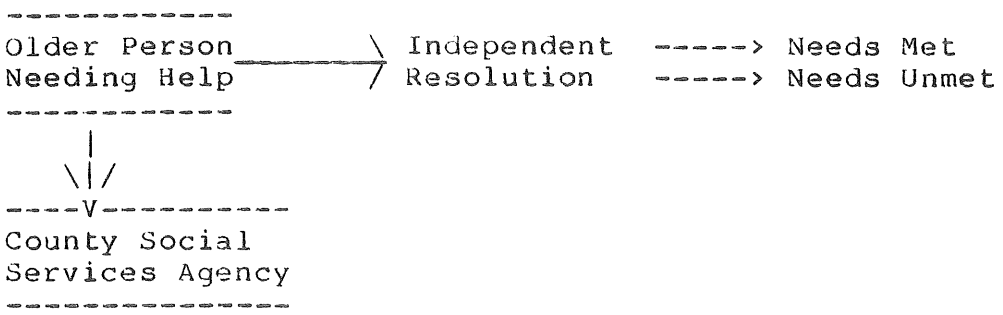
Only the seven services noted above are available through PAS/ACG, and only those who meet the test of means, and who are at risk of entering a nursing home receive services. Other ineligible older persons needing care may not receive the help they need. For persons not eligible for waivered services, or needing other services, counties face the same incentives for institutional placement.

E. Coordination and Case Management

Coordination and case management are two approaches for ensuring that persons needing help get appropriate care. Service coordination is the responsibility of agencies, and case management is more narrowly the responsibility of a individual case manager within the agency. Except for PAS/ACG, counties and other local agencies are not required to provide case management for older persons needing community services. Coordination, while very important, is a somewhat hollow requirement not taken seriously by all local governments. Using available sanctions to make local governments more accountable has not been generally considered effective, and incentives to encourage coordination are preferred.

Figure 7 shows how the case management process could work. Older persons may resolve their problems through their own initiative and resources, or with help from caregiving relatives or friends. Others may turn to county social service agencies for help.

Figure 7. ASSESSMENT AND CASE MANAGEMENT FLOW CHART



Case Manager: Assesses individual's needs and resources (personal and informal support) to develop a care plan and determine ability to pay; selects appropriate private and public programs and services.

Assessment/Selection

Needs	Personal/Other Resources	State/County Programs

- Housing	- Own home, equity
	- Other assets, income
	- Housing developments
	- Local housing programs
	- Informal support network
		- Housing Finance Agency:
		  - Section 8
		  - Rehab., accessibility
		  - Shared housing
		- Weatherization

- Income	- Own, spouse's income - Pensions, annuities - Social Security, SSI - Employment programs - Informal support network	- MSA - Food Stamps - Energy Assistance - Employment programs
- Services	- Local public/private programs - Informal support network	- Title III - CSSA, CHS - PAS/ACG - MA - Veterans programs

Case management was identified as a major gap in the long term care system in the state's 1982 Long Term Care Plan. In the absence of case management responsibilities, and the reliance on state encouragement of coordination, local agencies are able to put off these responsibilities because of a lack of state requirements and the existence of necessary resources.

F. Reinforcing the Informal Support System

Older Minnesotans are able to take care of 80 to 90 percent of their needs through the use of their own resources, and the help of families and friends. The public funds a relatively small portion of the need for long term care services. Individuals who are able and willing to pay for services need to have alternatives available to choose from in their community. To reinforce and support use of personal resources, and the informal caregiving network, respite services which can relieve the caregiver of responsibilities for a brief time need to be available.

For those persons who are not participating in the PAS/ACG Program, it is difficult to know whether the informal support system is excessively burdened or still an untapped resource. The key to making the most of the informal support system may be a combination of assessment, case management, and respite care. Neither case management nor assessment is required or available statewide for older persons except through PAS/ACG.

By assessing an individual's needs and resources, the case manager can make arrangements that anticipate and ensure full and fair

use of available public and private resources for persons needing long term care services who are not eligible for the PAS/ACG program. Private resources include not only the individual's resources, but the resources of family, friends and neighbors, the informal support system.

75 percent of older persons needing help with the activities of daily living are estimated to be assisted by their children; 33 percent are helped by their sisters or brothers, and less than 15 percent by their other relatives. Neighbors help older neighbors less than 15 percent of the time, though this help is often on an emergency basis, or a nonregular basis that could be compared to respite care.

The need for respite care was also considered a significant gap by the state's Long Term Care Plan. Children, most often a daughter, and others providing substantial care for older persons, often need a break from their responsibilities through respite care. Again the PAS/ACG program provides respite care for eligible persons, while others probably go largely unassisted. The availability of respite care may enable informal care givers to better handle their other responsibilities and stretch their resources over a longer period, thereby postponing or preventing institutionalization and reducing demands on publically funded programs.

In addition to respite care, the state should consider other means to encourage informal caregiving, from tax deductions to refundable tax credits, or direct payments to family members for care provided. These and other options are discussed in the state's Long Term Care Plan.

G. Service Targeting

Eligibility for these community services may be means tested (based on ability to pay) or simply categorical. MA has the most restrictive eligibililty standards, followed by Energy Assistance, Weatherization, and PAS/ACG, all of which are means tested. Many CSSA funded services are means tested, often involving a sliding scale fee. CHS, Title III, transit, and Veterans Home services are provided under universal or categorical eligibility, and are not means tested, although some effort may be made to target services. Eligibility for CDBG and CSBG services are determined by local agencies.

The usefulness of means tests for eligibility may be limited or restricted by the nature of some services, such as community health inspections, or by federal law, which prevents the state from using a means test for Title III services. Except for MA and PAS/ACG, local agencies are given the power to set nearly all of their own eligibility standards. To create statewide eligibility standards based on ability to pay for other programs would require a change in statutes and reduced local discretion.

Federal law with respect to Medical Assistance was recently changed to allow states to consider the resources of older persons families when determining who should pay for services that are needed. Idaho attempted to implement this new provision by requiring responsible children to pay a certain amount of the cost of care for parents in nursing homes. Because of the cost of setting up the enforcement mechanism, and because what the state had determined to be a fair share of these costs were often less than what families were

already paying, Idaho lost money and the program was abandoned. Issues related to family responsibility are especially sensitive, for they involve not only questions of and ability to pay, but also moral responsibility of children; these issues can be further complicated by volatile or strained personal relationships among family members.

Most residents of nursing homes have no living children or one child who might help them financially or with informal care. Policy directed at greater use of family members' resources for nursing home needs will therefore have limited effect on containing costs of public programs for nursing home care. The results of the baby boom will have important implications for informal caregiving. Because of the baby boom older persons around the turn of the century will have relatively higher numbers of children, while older persons in following decades will have relatively higher numbers of siblings. With this future demographic change related to the baby boom, the state will do well to develop policies and programs which provide incentives to encourage potential informal care givers.

Other ways to direct services to those who are in greatest need are contained in the Minnesota Strategy on Aging's companion reports on income support programs and housing. Income support programs offer cash assistance to low income elderly with few assets. By increasing the incomes of these persons, the state ensures that they are better able to purchase the services they may need. Through the development of alternative affordable housing arrangements, more older people can spend less on housing and more on their other needs.

III. RECOMMENDATIONS

The Minnesota Strategy on Aging is a series of strategies aimed at making programs and services more efficient and effective in meeting the needs of older persons in the State. The recommendations regarding the community services system are focused on enabling local governments to provide greater assistance to older individuals who may need help in managing some aspects of their lives. The Strategy on Aging recommendations provide counties with the responsibility and resources for planning and providing care to an increasing number of older Minnesotans.

A. COUNTY ROLES AND RESPONSIBILITIES

GOAL 1.: Strengthen the role of counties as the state's lead agency for community services in order to improve the effectiveness of the community services system, and to ensure that older individuals have access to appropriate community based services.

Recommendation 1.

Require that County Boards designate their social service agency as the lead agency responsible for aging services. Require counties to develop a more coordinated community services system plan, using a two-year operational planning cycle, and a four to six year strategic planning cycle.

Rationale: The state has given counties the largest part of the responsibility for delivering services to older Minnesotans under state funded programs. The state gives

county boards substantial discretion over the types and amounts of services they will provide through the many programs and agencies described in Section I. Recognizing that the state has given counties significant control over many programs serving older people, this recommendation will focus attention on a single agency, under the control of the county board.

Assigning this lead responsibility to county social service agencies will enhance the ability of older Minnesotans to have access to the services they need. Counties would be responsive to the inquiries and requests of older people, and responsible for ensuring that appropriate, needed care is provided.

Coordinated planning, on the same cycle for all programs, can reasonably address two years of operations, as is the case with most program plans currently in place. To provide the most meaningful basis for county boards' plans, submittal of CHS and CSSA plans should follow in the same year the State approves its biennial budget. Strategic planning should be timed in conjunction with the work of the Census Bureau and the State Demographer so that changes in demographics having significance for aging programs are available to the responsible agency.

Recommendation 2.

Standardize state program planning and reporting requirements to facilitate county coordination and evaluation of programs.

Strengthen the role of state agencies in providing technical assistance to aid the efforts of counties in planning and system development, including giving state agencies the discretion to stagger the due dates of comprehensive plan components within a year.

Rationale: Current state requirements create different burdens for counties depending on the type of agency administering state funded programs. Requirements for each program are also different, and may hinder the ability and likelihood of county agencies working closely together. Making the burden of state requirements the same for all agencies administering the same program, and reducing the differences in reporting and planning requirements between programs, should aid the efforts of local government and eventually reduce the costs of compliance with state laws and rules.

Recommendation 3.

Study the role of the Area Agencies on Aging as direct service providers to determine if county social service agency delivery of these services could improve coordination and service delivery. Determine if counties can provide program development and administration of Title III services at the same level of effeciency as Area Agencies and whether such consolidation will enhance the counties' role as the lead agency for aging services.

Rationale: All state administered, locally delivered social and health programs, except for Title III, are under the

jurisdiction of county boards, either singly or jointly with other counties. While the current system may provide a great variety of services through Title III, county controlled and delivered Title III services could provide a similar variety of programs.

The State Strategy on Aging has given greater responsibilities to counties to strengthen their ability to make the best use of the resources and programs of the state. To make the requirements for case management and planning by counties most meaningful, it appears that counties should have greater control over the state's locally delivered programs. Without this change, local service agencies in many areas of the state may not find any compelling reason for cooperation and coordination of their efforts, and may continue to duplicate their efforts on behalf of the elderly. In addition to better targeting and coordination, there is potential for increased efficiency through economies of scale in the consolidation of program administration and planning. Counties could include this plan as one of its components in its coordinated community services system plan.

B. COUNTY FISCAL INCENTIVES

GOAL 2.: Improve county fiscal incentives favoring the development, expansion, and use of noninstitutional long term care programs.

Recommendation 1.

Increase county Medical Assistance (MA) match requirements for nursing home care from 10 to 25 percent of the nonfederal share, and transfer the corresponding state MA fund savings to counties to meet the increased match requirement, and to develop or expand noninstitutional long term care services.

Rationale: County incentives for institutional placements must be reduced if the state wants to rely more on noninstitutional services. However, counties should not be expected to accept an increased financial burden, or significant changes in program responsibilities, without assurances from the state that it will provide funds to pay for such changes, and help counties to develop alternative programs and services.

The Minnesota Department of Human Services has estimated that the total nonfederal share of Medicaid costs for nursing homes in state fiscal year 1986 will be $231.3 million. The state share would be $208.2 million and the county share would total $23.1 million. Increasing the county match to 25 percent of the nonfederal share would result in a reduction in state Medicaid costs of $34.7 million. The full amount of the state's MA fund savings would be transferred to counties

to help them pay for the increased share of nursing home costs, as well as to develop noninstitutional alternative care programs. The actual amount to be transferred by the state in 1986 would be an inflation adjusted total based on actual county expenditures in 1984.

If counties continue to utilize nursing homes at the same rate, they will be held harmless by the transfer, as funds would merely revolve back to counties to pay for nursing home care. If counties utilize nursing homes at a lower rate, they will eventually be able to use "freed-up" funds from the transfer for some other long term care services. However, the amount of "freed-up" funds are likely to be limited due to the continuing need for nursing home beds. If counties increase their rate of nursing home utilization, they will face a 15 percent greater nonfederal share of only these additional costs.

The formula for the reallotment would be based on historic utilization of nursing homes and would hold counties harmless for continuing the same rate of utilization. Funds not used to meet matching requirements would be used to fund alternative care services, as chosen by counties, to help prevent or postpone institutionalization. Since Minnesota has the third highest rate of nursing home utilization in the country, it seems likely that counties will eventually be able to reduce their rate of utilization as alternative care programs are more fully developed.

Recommendation 2.

Continue the nursing home bed certification moratorium.

Rationale: While the State Strategy on Aging did not deal directly with nursing homes, in its consultation with the Department of Human Services on the progress of rule promulgation related to case-mix reimbursement, and with the Department of Health regarding quality assurance, there was no strong reason to remove the moratorium.

In fact, continuation of the moratorium is a crucial part of the Strategy on Aging. If counties are to be given responsibility as lead agency for the elderly with accompanying responsibility for development of the continuum of long term care services, they must be able to control the entire system. A strong Preadmission Screening program coupled with a state policy of no growth in nursing home beds will enable counties to develop alternative services and not be at risk for payment of additional nursing home beds constructed by private interests.

In addition, since Minnesota already institutionalizes 9 percent of its elderly as opposed to 5 percent nationally, the institutional system already appears to be more than adequate. In fact, if no new nursing home beds were constructed between now and 1990, Minnesota would institutionalize 8.5 percent of its elderly, a percentage still far above the national average. Since increasing numbers of elderly will require long term care services in

the next five years, the state should focus those required additional resources on community services rather than on additional bed construction. The recommendations from the Strategy on Aging can be seen as a solution to the problem of how to provide needed services to increasing numbers of frail elderly while also retaining the moratorium.

C. ALTERNATIVE LONG TERM CARE SERVICES; CASE MANAGEMENT

GOAL 3.: Ensure that older Minnesotans are better able to lead fulfilling lives and maximize their independence through accessible and coordinated community services which can help prevent or postpone institutionalization.

Recommendation 1.

Continue the Medicaid waiver for alternative care grants.

Rationale: This is perhaps the most important and successful alternative care program in the state, because of its ability to provide care which postpones or prevents institutionalization, reduce overall costs of care to state and local government, and attract federal funds to help pay for services. The state should make every effort to continue, and if possible, expand the Medicaid waiver.

Recommendation 2.

Allocate state funds available for Alternative Care Grants for 180-day eligible persons directly to counties according to the existing formula, and continue the 10 percent county match

requirement. Counties can then use these funds in conjunction with the state MA transfer funds to pay for alternative care services. In addition, the state will make a new allocation of $2.0 million per year for case management by counties for older Minnesotans receiving long term care community services. Non-MA Alternative Care Grant Funds, the state MA transfer, and the new case management funding will be combined into a Community Care Incentive Fund. Table 7. shows how funds would flow based on the recommended changes which create the Community Care Incentive Fund (CCIF).

Unlike the current Alternative Care Grant Program for persons not eligible for Medical Assistance, the funds allocated to counties through the Community Care Incentive Fund could be used for persons who do not meet the the 180-day MA eligibility criterion, and for services beyond the seven which are allowed by the current PAS/ACG program. Counties would select and provide those services which it believes will be best able to help older people continue to live in their own home or other noninstitutional setting. As with services, eligibility standards for persons needing alternative care services would be determined by each county, and would rely on the incentives against nursing home placement created by the change in the counties share for nursing home MA costs.

With respect to the new allocation of $2.0 million per year for case management, counties would have the responsibility to work with (1) Clients to assess their abilities, needs, resources and informal support network to develop care plans appropriate to

their circumstances, and to help manage and arrange needed community services; and (2) Providers to ensure coordination and timely provision of services according to the individual's care plan.

Rationale: This recommendation is the final link in the strategy to enable counties to provide noninstitutional community care, and avoid the greater costs of institutional placement. The incentives to reduce current and future costs created by these recommendations should guide the counties toward the provision of a contiuum of services.

Along with the change in MA nursing home expenditure match requirements, counties should be given the power to manage the resources made available by the state for alternative care services, as they are given power over other categorical and community service block grants. This authority will not only be more acceptable to counties, but will allow the state to monitor progress and see if there are any especially effective programs which can be shared among counties.

TABLE 7. STATE MEDICAL ASSISTANCE FUND TRANSFER AND COMMUNITY CARE INCENTIVE FUND

I. MEDICAL ASSISTANCE (MA) FUND TRANSFER

Change County match on MA nursing home costs (SNF, ICF-I, ICF-II) from 10 percent to 25 percent of the nonfederal share.

	MA Expenditures (in millions)			
	State	Percent	County	Percent
Current Law	$208.2	90	$23.1	10
Proposed	$173.5	75	$57.8	25
Change	-$34.7		+$34.7	

II. COMMUNITY CARE INCENTIVE FUND

Transfer State MA savings, Non-MA PAS/ACG, and new case management funds to Counties for community based alternative care services.

FUNDS AVAILABLE TO COUNTIES		
MA Transfer		$34.7
Non-MA PAS/ACG		$17.8
FY86 Base	$5.0	
Department Change Request	$11.0	
County Match	$1.8	
Case Management		$2.0
TOTAL		$54.5*

* - $54.5 million available to counties to pay for:

1) 15 % extra share for nursing home costs (up to $34.7 million).

2) Community based alternative care services for all non-MA elderly.

3) Case Management.

4) Coordination.

APPENDIX A.

MINNESOTA STRATEGY ON AGING TASK FORCE

Chair: Nellie Johnson
Department of Finance

Members: Dean Honetschlager
State Planning

Richard Nelson
Minnesota Board on Aging

James Parker
Department of Health

Allan Schenkelberg
Department of Transportation

James Solem
Housing Finance Agency

Betsy Walton
Department of Human Services

STRATEGY ON AGING STUDY

Director: Nellie Johnson
Department of Finance

Team Leaders: Monte Aaker
Housing Finance Agency

Nancy Feldman
Department of Finance

Co-Workers: (issue areas) Carol Anderson
(Income Support Programs; Long Term Health Care Insurance)

Bob Mayer
(Community Social and Health Services; Demographic Profile)

David Siburg
(Housing; Home Equity Conversion)

APPENDIX B.

COMMUNITY SERVICES PROGRAM SUMMARIES

1. Department of Economic Security

Name of Program: COMMUNITY SERVICES BLOCK GRANT (CSBG)

Purpose and Objectives: To identify and eliminate the causes of poverty by providing services to low income persons, and resources which strengthen community based organizations representing the interests of low income persons on a local level. Major emphasis of program is to provide funds for local agency staff (program, planning, and support) for the activities funded by public and private sources.

Funding Sources: (millions of dollars)	SFY81	SFY82	SFY83	SFY84	SFY85
Local		1.5			
State	1.2	2.2	1.0	1.1	1.1
Federal	0.2	1.2	5.4	5.4	5.4
Other		2.0			
Totals		6.9			

Eligibility Requirements: Local agencies are certified community action agencies or eligible tribal organizations. Individual eligibility requirements vary by program.

Administration and Planning: Minnesota Department of Economic Security distributes federal CSBG funds and Minnesota Equal Opportunity Grants to local government or nonprofit community action agencies on the basis of poverty population.

Services: Funds are used to provide and administer nutrition programs including commodity distribution and Title III, energy and and weatherization assistance, social, recreational, transportation, employment (RSVP, foster grandparent, senior companion, VITA) programs, discount cards, chore and home services.

Persons Served: In federal fiscal year 1982 (FFY82) there was a duplicated count of 41,753 elderly served for senior-targeted programs; other programs are not broken down by age.

Other Data: About $60 million worth of commodities were distributed in the past year.

2. Department of Economic Security (cont.)

Name of Program: ENERGY ASSISTANCE: TITLE XXVI

Purpose and Objectives: To assist low income households in meeting the costs of home energy. To reduce current and future energy consumption and energy expenditures of low income households.

Funding Sources: (millions of dollars)	FFY81	FFY82	FFY83	FFY84	FFY85
Local					
State	2.0				
Federal	69.6	74.3	78.3	82.2	
Other					
Totals	71.6	74.3	78.3	82.2	

Eligibility Requirements: Households with incomes less than or equal to 60 percent of the state's median income. Must be income and asset eligible (asset limit of $25,000).

Administration and Planning: Department of Economic Security administers the federal block grant and monitors local delivery, predominantly by Community Action Agencies, and including indian tribal communities, to ensure compliance with program standards.

Services: Assistance in paying fuel bills. Home owners received $500 or less for conservation repairs in 1983, which was paid to vendors doing the repairs.

Persons Served: In federal FY 1983, 123,902 households were served, including 38,861 elderly (31 percent), 5,657 SSI, and 24,096 food stamp households. It is estimated that in FFY84 about 43,000 (31%) of 139,000 households served will include an elderly (age 60+) person.

Other Available Data: Energy Assistance Program Annual Reports.

1. Department of Economic Security (cont.)

Name of Program: WEATHERIZATION

Purpose and Objectives: To complete weatherization improvements on all eligible low income households in Minnesota to reduce energy consumption and ensure safety by the end of FFY85. To allocate federal Department of Energy training and technical assistance to local agencies and contractors.

Funding Sources: (millions of dollars)	SFY81	SFY82	SFY83	SFY84	SFY85
Local					
State	8.6	9.7	0.01	3.8	5.7
Federal	19.0	6.2	26.35	19.3	10.1
Other					
Totals	27.6	15.9	26.4	23.1	15.8

Eligibility Requirements: Households 125% of poverty, less than $11,625 for a family of four (Office of Management and Budget standards) of which there are about 100,000 in Minnesota. Energy audit determines the type of weatherization activity. Seniors, handicapped persons, and fuel oil users have program priority.

Administration and Planning: Department of Economic Security administers the program by contracting with 26 community action agencies, 3 counties, and 8 indian reservations.

Services: Insulation, stoppage of air infiltration, window and door repair or replacement, and repairs and replacement of roofs, chimneys, and furnaces. Current studies indicate energy savings of 13 to 25 percent from improvements.

Persons Served: In calendar year 1983, about 11 percent of 1880 households served included an elderly member.

Other Available Data: Rate of services to the elderly has declined from earlier disproportionate large share of households served, a decline from over 30 percent of all households, to around 12 percent. Program is intended to be phased down after 1985, as most eligible households will have been served.

2. Department of Energy and Economic Development

Name of Program: COMMUNITY DEVELOPMENT BLOCK GRANTS (CDBG)

Purpose and Objectives: Development of viable urban communities by providing decent housing and a suitable living environment, and expanding economic opportunities, principally for low and moderate income persons.

Funding Sources: (millions of dollars)	SFY81	SFY82	SFY83	SFY84	SFY85
Local	NA	NA	NA	NA	NA
State			.3	.3	.3
Federal	18.3	22.5	22.5	22.5	22.5
Other					
Totals					

Eligibility Requirements: Low and moderate income households (section 8 housing guidelines) must be the majority of program beneficiaries.

Administration and Planning: Department of Energy and Economic Development administers program to small cities, counties, and townships, providing gratns for eligible activities. Local housing authorities or development agencies carry out programs. Larger cities adn counties receive direct entitlements from US Department of Housing and Urban Development.

Services: Housing rehabilitation, economic development, and employment can benefit older persons, but is not targeted toward them. Public services can include homemaker, chore, and nutrition, and may make up to 15 percent of total agency CDBG expenditures.

Other Available Data: Distribution of program beneficiaries by income. An additional $33,231,000 was granted directly to Minnesota counties and cities in 1984 by the US Department of Housing and Urban Development.

3. Department of Health

Name of Program: COMMUNITY HEALTH SERVICES BLOCK GRANT (CHS)

Purpose and Objectives: To develop and maintain an integrated system of community health services under local administration with state fiscal support and using state guidelines and standards, designed to protect and improve public health by providing and coordinating community health services.

Funding Sources: (millions of dollars)	SFY81	SFY82	SFY83	SFY84	SFY85
Local	23.4	24.3	24.4	NA	NA
State*	12.4	12.1	12.7	11.2+	11.5+
Federal**	6.1	5.9	6.6	NA	NA
Other	28.6	29.9	32.7		
Totals	70.5	72.2	76.4		

*Includes both CHS subsidy and other special state grants (home care demonstration grants, family planning grants, etc.).
**Special federal funds (WIC, family planning, hypertension, refugee health, block grants, etc.).
+Includes only state appropriations. Other figures will not be available until the close of the fiscal year.

Eligibility Requirements: "Eligibility" is uniform for all services provided. Local Boards of Health must meet statutory requiremetns and submit biennial community plan addressing six program areas (community nursing, home health, environmental health, emergency medical services, dental health, and health education), coordination and integration with other human services, citizen participation, and evaluation of prior years' efforts.

Administration and Planning: City, county, and multi-county agencies administer and plan services using state guidelines and planning standards. Commisisoner of Health approves plans and allocates state CHS and some federal funds according to a formula based on per capita income, tax base, and previous per capita CHS expenditures.

Services: Community nursing, home health, dental health, environmental health, health education, disease prevention and control, and emergency medical services.

Persons Served: All residents of Minnesota are eligible for services. Detailed service information will be available for CHS in late 1984.

Other Available Data: Expenditure reports (MDH, District Services); biennial plans, annual reports, and statistical program reports of local CHS agencies; health status data; health professionals licensure data; and health facilities information system.

4. Department of Human Services

Name of Program: COMMUNITY SOCIAL SERVICES ACT (CSSA)/TITLE XX

Purpose and Objectives: To plan and provide for a system of community social services by boards of county commissioners under the supervision of the commissioner of human services, to aid eight target populations identified by the state, including vulnerable adults, and elderly who are experiencing difficulty living independently.

Funding Sources: (millions of dollars)	CY81	CY82	CY83	CY84	CY85
Local	92.3	101.4	136.7	139.4	
State	48.7	60.3	56.0	59.4	
Federal	51.9	44.6	41.6	42.8	
Other	6.4	7.1	20.1	26.6	
Totals	199.3	213.4	254.4	268.2	

Eligibility Requirements: Counties must submit biennial CSSA and Title XXM (federal) plan. Persons age 60+ are considered the elderly target group, with income standard (sliding fee or free for those with 60 percent of the state median income) for most services provided.

Administration and Planning: State commissioner of human services certifies county plans and distributes state funds and Title XX funds according to their respective formulas: CSSA according to 1) AFDC, MA, and GA caseloads, 2) population, and 3) population age 65+; Title XX according to 1) AFDC, MA, SSI, and MSA caseload, and 2) population.

Services: Funds 49 social services, all of which were provided to persons age 65+ in the state. The elderly received assistance most often through the following services: aftercare, assessment, chore, case management, counseling and therapy, adult day care, adult foster care, health services, home delivered and congregate meals, homemaking, housing services, information and referral, and adult protection.

Persons Served: In 1982, counties reported a duplicated count of 62,945 elderly persons served, 14.8% of all persons whose age was known (68,980 persons were served whose age was unknown). See Table B1 1for selected service data.

Other Available Data: As few as 12 and as many as 83 (of 83) counties provided each of 49 services in 1982. Serivces to target population age 60+ was estimated in county plans for 1983: 244,236 persons at a cost of $18,806,389; for 1984: 255,827 persons served at a cost of $20,035,993. Funds described above include programs not part of CSSA or Title XX, such as mental health deinstitutionalization, child care sliding fee, and Titles IV-A and IV-E of the Social Security Act.

Table B-1. NUMBER OF PERSONS SERVED AGE 65+ BY PROGRAMS UNDER CSSA FUNDING FOR CALENDAR YEAR 1982

	PERSONS SERVED				
	direct		purchased		total
SERVICE	number	percent	number	percent	number
aftercare	579	60.56%	377	39.44%	956
assessment	1483	24.48%	4574	75.52%	6057
case consulting	111	8.73%	1160	91.27%	1271
chore	3650	37.64%	6048	62.36%	9698
counseling	1854	22.10%	6535	77.90%	8389
CD early assessment	9	3.36%	259	96.64%	268
DAC-adult	164	50.00%	164	50.00%	328
day care-adult	286	49.83%	288	50.17%	574
day care-child	107	32.92%	218	67.08%	325
day treatment	16	11.19%	127	88.81%	143
detox	501	54.05%	426	45.95%	927
foster care-adult	103	95.37%	5	4.63%	108
foster care-child	85	83.33%	17	16.67%	102
general health	3283	42.21%	4495	57.79%	7778
homemaker	3372	67.43%	1629	32.57%	5001
housing	743	100.00%	0	0.00%	743
info & referral	4677	33.29%	9371	66.71%	14048
legal	297	99.66%	1	0.34%	298
money management	937	99.79%	2	0.21%	939
nutrition	760	20.73%	2907	79.27%	3667
protection-adult	2237	91.46%	209	8.54%	2446
protection-child	269	98.90%	3	1.10%	272
residential care	651	79.78%	165	20.22%	816
social/recreational	1107	17.52%	5211	82.48%	6318
transportation	3026	61.84%	1867	38.16%	4893
TOTAL*	31219	39.95%	46921	60.05%	78140

* Total includes services funded by CSSA not listed here.

Source: Minnesota Department Of Human Services, 1982 CSSA Effectiveness Report

4. Department of Human Services (cont.)

Name of Program: MEDICAL ASSISTANCE (MA)

Purpose and Objectives: To assist low income perons who cannot afford the cost of necessary medical services.

Funding Sources: (millions of dollars)	SFY81	SFY82	SFY83	SFY84	SFY85
Local	26.4	34.5	39.9	46.5	49.8
State	265.4	311.1	350.1	418.5	448.0
Federal	366.0	404.0	440.4	482.2	540.9
Other					
Totals	657.8	749.6	839.4	947.1	1,038.6

Eligibility Requirements: Categorically needy: meet (SSI/MSA) income limits of $344 per month, resource limit of $2000. Medically needy: would otherwise be eligible of income and assets were spent on covered medical services.

Administration and Planning: US Department of Health and Human Services (DHHS) provides generaly program requirements, with Health Care Finance Administration (HCFA) issuing regulations and guidelines. Department of Human Services supervises local program administration and issues payments to service providers. Counties determine applicant eligibility.

Services: Federally mandated: in and outpatient hospitalization, laboratory and x-ray services, skilled nursing facilities, early and periodic screening, physician services, family planning, and home health care. Optional services: mental health, HMO enrollment, rehabilitation, intermediate care facilities, public health nursing, prescription drugs, medical supplies and transportation, dentistry, phsychiatry, optometry, private duty nursing, physical and speech therapy, podiatry, audiology, services to handicapped children.

Persons Served: SFY81 average monthly caseload was 135,472, with 33,056 elderly (24%). SFY82 average monthly casload was 134,906, with 33891 (25%) elderly. SFY83 average montly caseload was 135,520, with 36,274 elderly (24%). SFY83 elderly persons ever eligible for MA: categorically needy totaled 14,156, with most persons age 65 to 79; medically needy totaled 38,455, with most persons age 80+.

Other Available Data: About 57 percent of nursing home residents have their care payed for by MA in the state. About 55 percent of nursing home residents are estimated to have a private pay background (more than 15 days); about 57 percent of these persons have private pay periods of 12 months or less (does not count nursing home transfers). Department of Human Services issues monthly service statistical reports, and annual expenditure reports of actual and projected expenditures.

4. Department of Human Services (cont.)

Name of Program: PREADMISSION SCREENING

Purpose of Screening: To assess persons who are 65 years or older and applicants to nursing homes and boarding care homes to determine if they are able to remain in the community or are appropriate for admission to a nursing home or boarding care home. Only facilities which are certified for skilled, intermediate care I or intermediate care II are affected by this program.

Who Must be Screened: Persons who are 65 years or older, applicants to certified nursing homes or boarding care homes, and MA eligible or eligible for Medicaid within 180 days of admisison to the certified facility.

Who May be Screened: Any person who is 65 years or older and requests and screening.

Cost of Screening: The state will reimburse counties for the full cost of screenings up to $125 for MA and 180-day eligible eligible persons; reimbursement for other persons screened is based on a sliding scale according to screened individual's gross income only (full cost charged to person/county for income over $17,500).

Composition of Screening Team: By State law the screening team must be composed of a county social worker and a county public health nurse. The person's attending physician may participate if she or he so desires. A consulting physician is also available if needed.

Who is Involved in the Screening: Each county screening team must involve the elderly person and their family. The team may consult with other informal and formal caregivers.

Recommendation: The county screening team makes recommendations based on the needs of the client and the support available (informal and formal care); the team must recommend community placement if the person can be maintained in the community for a cost equal to or less than nursing home placement, and if needed services are available.

Outcome: The elderly person or their responsible party makes the final decision as to whether to remain in the community or enter a nursing home or boarding care home. With community placement, including ACG waivered services, the county is responsible for coordinated case management to ensure that all services are provided according to the individual's care plan. Primary case management is performed by a single person for all services.

PAS significant program characteristics:
1) Mandatory county participation since July 1, 1983; 2) Average age of client screened is 81 years; 3) $357,000 of $600,000 allocation spent in SFY84, $850,000 allocated for screenings in SFY85; 4) PAS for persons transferring from hospitals or nursing homes to any nursing home will become mandatory in 1985, adding an estimated 7,000 screenings each year. See Tables B-2 and B-3, and Figure B-1.

TABLE B-2A. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION ONE TOTAL								
MA eligible	53	23	43%	33	62%	22	42%	56
180-Day eligible	108	44	41%	63	58%	45	42%	
TOTAL	175	68	39%	105	60%	67	38%	
REGION TWO TOTAL								
MA eligible	51	18	35%	33	65%	22	43%	40
180-Day eligible	64	21	33%	43	67%	34	53%	
TOTAL	120	39	33%	79	66%	58	48%	
REGION THREE TOTAL								
MA eligible	152	73	48%	84	55%	56	37%	97
180-Day eligible	320	147	46%	180	56%	121	38%	
TOTAL	520	248	48%	271	52%	179	34%	
REGION FOUR TOTAL								
MA eligible	92	47	51%	43	47%	27	29%	73
180-Day eligible	184	98	53%	89	48%	58	32%	
TOTAL	295	150	51%	145	49%	89	30%	
REGION FIVE TOTAL								
MA eligible	111	61	55%	50	45%	33	30%	59
180-Day eligible	248	116	47%	132	53%	76	31%	
TOTAL	363	176	48%	186	51%	111	31%	
REGION SIX TOTAL								
MA eligible	77	27	35%	50	65%	37	48%	83
180-Day eligible	162	54	33%	108	67%	85	52%	
TOTAL	257	88	34%	168	65%	124	48%	
REGION SEVEN TOTAL								
MA eligible	119	53	45%	66	55%	44	37%	101
180-Day eligible	370	186	50%	184	50%	100	27%	
TOTAL	504	244	48%	256	51%	144	29%	
REGION EIGHT TOTAL								
MA eligible	90	40	44%	45	50%	29	32%	58
180-Day eligible	75	40	53%	33	44%	26	35%	
TOTAL	169	84	50%	83	49%	55	33%	
REGION NINE TOTAL								
MA eligible	80	32	40%	48	60%	35	44%	74
180-Day eligible	156	89	57%	67	43%	45	29%	
TOTAL	248	125	50%	120	48%	81	33%	
REGION TEN TOTAL								
MA eligible	157	65	41%	92	59%	74	47%	143
180-Day eligible	386	102	26%	272	70%	212	55%	
TOTAL	580	183	32%	395	68%	290	50%	
REGION ELEVEN TOTAL								
MA eligible	436	111	25%	325	75%	244	56%	395
180-Day eligible	1447	404	28%	1043	72%	801	55%	
TOTAL	2072	569	27%	1499	72%	1048	51%	
STATE TOTAL								
MA eligible	1418	550	39%	869	61%	623	44%	1179
180-Day eligible	3520	1301	37%	2214	63%	1603	46%	
TOTAL	5303	1974	37%	3307	62%	2246	42%	

FIGURE B-1. PERCENTAGE OF PERSONS SCREENED PLACED ON ACG, BY ELIGIBILITY IN SFY84

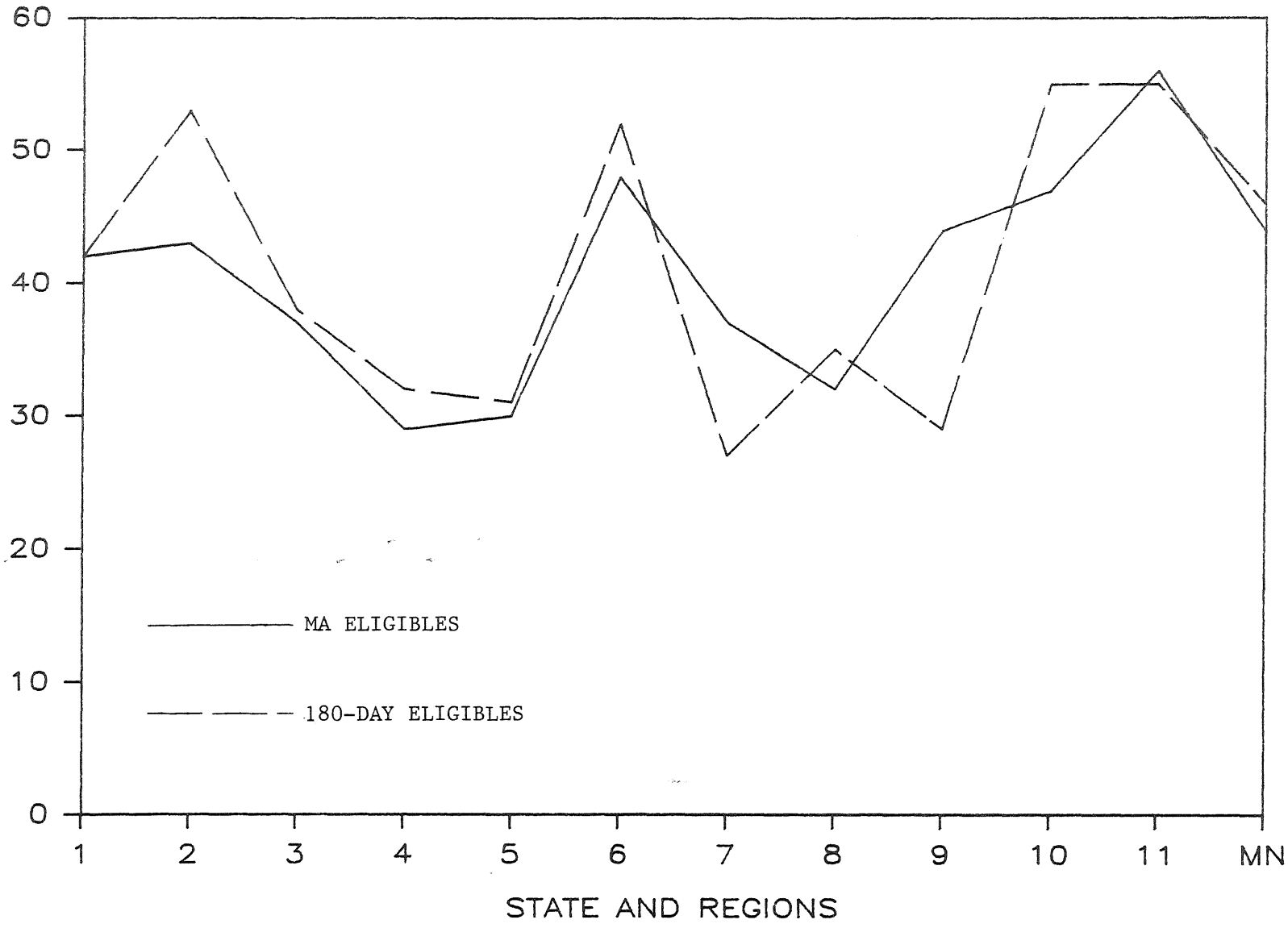


TABLE B-2B. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION ONE								
KITTSON								
MA eligible	2	1	50%	1	50%	1	50%	4
180-Day eligible	9	6	67%	3	33%	3	33%	
TOTAL	11	7	64%	4	36%	4	36%	
MARSHALL								
MA eligible	1	1	100%	0	0%	0	0%	5
180-Day eligible	9	1	11%	8	89%	6	67%	
TOTAL	11	3	27%	8	73%	6	55%	
NORMAN								
MA eligible	5	0	0%	5	100%	3	60%	5
180-Day eligible	19	9	47%	10	53%	9	47%	
TOTAL	24	9	38%	15	63%	12	50%	
PENNINGTON								
MA eligible	10	6	60%	4	40%	2	20%	7
180-Day eligible	12	7	58%	5	42%	5	42%	
TOTAL	23	13	57%	9	39%	7	30%	
POLK								
MA eligible	27	8	30%	22	81%	16	59%	20
180-Day eligible	31	12	39%	19	61%	9	29%	
TOTAL	66	20	30%	46	70%	25	38%	
RED LAKE								
MA eligible	1	1	100%	0	0%	0	0%	6
180-Day eligible	9	4	44%	5	56%	4	44%	
TOTAL	11	5	45%	6	55%	4	36%	
ROSEAU								
MA eligible	7	6	86%	1	14%	0	0%	9
180-Day eligible	19	5	26%	13	68%	9	47%	
TOTAL	29	11	38%	17	59%	9	31%	
REGION ONE TOTAL								
MA eligible	53	23	43%	33	62%	22	42%	56
180-Day eligible	108	44	41%	63	58%	45	42%	
TOTAL	175	68	39%	105	60%	67	38%	

TABLE B-2C. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION TWO								
BELTRAMI								
MA eligible	28	8	29%	20	71%	13	46%	12
180-Day eligible	28	6	21%	22	79%	18	64%	
TOTAL	57	14	25%	42	74%	31	54%	
CLEARWATER								
MA eligible	6	1	17%	5	83%	3	50%	12
180-Day eligible	12	1	8%	11	92%	10	83%	
TOTAL	21	2	10%	19	90%	15	71%	
HUBBARD								
MA eligible	9	3	33%	6	67%	5	56%	6
180-Day eligible	10	5	50%	5	50%	3	30%	
TOTAL	19	8	42%	11	58%	8	42%	
LAKE OF THE WOODS								
MA eligible	4	4	100%	0	0%	0	0%	4
180-Day eligible	7	7	100%	0	0%	0	0%	
TOTAL	12	11	92%	0	0%	0	0%	
MAHNOMEN								
MA eligible	4	2	50%	2	50%	1	25%	6
180-Day eligible	7	2	29%	5	71%	3	43%	
TOTAL	11	4	36%	7	64%	4	36%	
REGION TWO TOTAL								
MA eligible	51	18	35%	33	65%	22	43%	40
180-Day eligible	64	21	33%	43	67%	34	53%	
TOTAL	120	39	33%	79	66%	58	48%	

TABLE B-2D. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
State Fiscal Year 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION THREE								
AITKIN								
MA eligible	13	0	0%	6	46%	6	46%	11
180-Day eligible	20	7	35%	20	100%	13	65%	
TOTAL	36	7	19%	29	81%	21	58%	
CARLTON								
MA eligible	15	2	13%	13	87%	8	53%	14
180-Day eligible	36	6	17%	30	83%	24	67%	
TOTAL	52	9	17%	43	83%	32	62%	
COOK								
MA eligible	0	0		0		0		4
180-Day eligible	0	0		0		0		
TOTAL	0	0		0		0		
ITASCA								
MA eligible	5	2	40%	3	60%	2	40%	8
180-Day eligible	27	9	33%	18	67%	6	22%	
TOTAL	32	11	34%	21	66%	8	25%	
KOOCHICHING								
MA eligible	6	6	100%	2	33%	0	0%	5
180-Day eligible	8	6	75%	2	25%	1	13%	
TOTAL	20	17	85%	4	20%	1	5%	
LAKE								
MA eligible	16	11	69%	5	31%	3	19%	11
180-Day eligible	35	22	63%	13	37%	10	29%	
TOTAL	84	60	71%	24	29%	14	17%	
ST. LOUIS								
MA eligible	97	52	54%	55	57%	37	38%	44
180-Day eligible	194	97	50%	97	50%	67	35%	
TOTAL	296	144	49%	150	51%	103	35%	
REGION THREE TOTAL								
MA eligible	152	73	48%	84	55%	56	37%	97
180-Day eligible	320	147	46%	180	56%	121	38%	
TOTAL	520	248	48%	271	52%	179	34%	

TABLE B-2 E. PREADMISISON SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION FOUR								
BECKER								
MA eligible	16	8	50%	8	50%	3	19%	9
180-Day eligible	29	8	28%	21	72%	14	48%	
TOTAL	46	16	35%	30	65%	17	37%	
CLAY								
MA eligible	8	7	88%	1	13%	1	13%	5
180-Day eligible	16	12	75%	4	25%	3	19%	
TOTAL	27	19	70%	7	26%	5	19%	
DOUGLAS								
MA eligible	20	9	45%	11	55%	10	50%	13
180-Day eligible	42	20	48%	22	52%	18	43%	
TOTAL	63	30	48%	33	52%	28	44%	
GRANT								
MA eligible	5	2	40%	1	20%	1	20%	5
180-Day eligible	5	4	80%	3	60%	1	20%	
TOTAL	10	6	60%	4	40%	2	20%	
OTTER TAIL								
MA eligible	32	13	41%	19	59%	10	31%	21
180-Day eligible	72	39	54%	34	47%	19	26%	
TOTAL	118	56	47%	63	53%	32	27%	
POPE								
MA eligible	6	5	83%	1	17%	1	17%	6
180-Day eligible	10	7	70%	3	30%	1	10%	
TOTAL	16	12	75%	4	25%	2	13%	
STEVENS								
MA eligible	3	3	100%	0	0%	0	0%	4
180-Day eligible	3	3	100%	0	0%	0	0%	
TOTAL	6	6	100%	0	0%	0	0%	
TRAVERSE								
MA eligible	0	0		0		0		4
180-Day eligible	4	4	100%	0	0%	0	0%	
TOTAL	4	4	100%	0	0%	0	0%	
WILKIN								
MA eligible	2	0	0%	2	100%	1	50%	6
180-Day eligible	3	1	33%	2	67%	2	67%	
TOTAL	5	1	20%	4	80%	3	60%	
REGION FOUR TOTAL								
MA eligible	92	47	51%	43	47%	27	29%	73
180-Day eligible	184	98	53%	89	48%	58	32%	
TOTAL	295	150	51%	145	49%	89	30%	

TABLE B-2F. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION FIVE								
CASS								
MA eligible	23	16	70%	7	30%	5	22%	11
180-Day eligible	30	10	33%	20	67%	14	47%	
TOTAL	54	26	48%	28	52%	20	37%	
CROW WING								
MA eligible	44	29	66%	15	34%	9	20%	25
180-Day eligible	141	82	58%	59	42%	23	16%	
TOTAL	186	111	60%	74	40%	32	17%	
MORRISON								
MA eligible	14	5	36%	9	64%	7	50%	9
180-Day eligible	20	11	55%	9	45%	9	45%	
TOTAL	35	16	46%	19	54%	16	46%	
TODD								
MA eligible	14	4	29%	10	71%	4	29%	9
180-Day eligible	37	9	24%	28	76%	18	49%	
TOTAL	51	12	24%	39	76%	23	45%	
WADENA								
MA eligible	16	7	44%	9	56%	8	50%	5
180-Day eligible	20	4	20%	16	80%	12	60%	
TOTAL	37	11	30%	26	70%	20	54%	
REGION FIVE TOTAL								
MA eligible	111	61	55%	50	45%	33	30%	59
180-Day eligible	248	116	47%	132	53%	76	31%	
TOTAL	363	176	48%	186	51%	111	31%	

TABLE B-2G. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION SIX EAST								
KANDIYOHI								
MA eligible	10	6	60%	4	40%	2	20%	10
180-Day eligible	28	11	39%	17	61%	14	50%	
TOTAL	42	17	40%	25	60%	16	38%	
MCLEOD								
MA eligible	20	3	15%	17	85%	16	80%	25
180-Day eligible	60	10	17%	50	83%	45	75%	
TOTAL	83	12	14%	71	86%	63	76%	
MEEKER								
MA eligible	6	3	50%	3	50%	2	33%	8
180-Day eligible	12	6	50%	6	50%	2	17%	
TOTAL	19	10	53%	9	47%	4	21%	
RENVILLE								
MA eligible	4	0	0%	4	100%	3	75%	9
180-Day eligible	19	10	53%	9	47%	7	37%	
TOTAL	24	10	42%	14	58%	10	42%	
REGION SIX WEST								
BIG STONE								
MA eligible	7	3	43%	4	57%	2	29%	4
180-Day eligible	2	2	100%	0	0%	0	0%	
TOTAL	9	5	56%	4	44%	2	22%	
CHIPPEWA								
MA eligible	8	5	63%	3	38%	1	13%	4
180-Day eligible	9	6	67%	3	33%	1	11%	
TOTAL	22	16	73%	6	27%	2	9%	
LAC QUI PARLE								
MA eligible	4	2	50%	2	50%	1	25%	5
180-Day eligible	3	1	33%	2	67%	0	0%	
TOTAL	7	3	43%	4	57%	1	14%	
SWIFT								
MA eligible	13	3	23%	10	77%	9	69%	10
180-Day eligible	17	4	24%	13	76%	9	53%	
TOTAL	33	9	27%	24	73%	18	55%	
YELLOW MEDICINE								
MA eligible	5	2	40%	3	60%	1	20%	8
180-Day eligible	12	4	33%	8	67%	7	58%	
TOTAL	18	6	33%	11	61%	8	44%	
REGION SIX TOTAL								
MA eligible	77	27	35%	50	65%	37	48%	83
180-Day eligible	162	54	33%	108	67%	85	52%	
TOTAL	257	88	34%	168	65%	124	48%	

TABLE B-2H. PREADMISISON SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION SEVEN								
BENTON								
MA eligible	16	16	100%	0	0%	0	0%	5
180-Day eligible	54	48	89%	6	11%	2	4%	
TOTAL	70	64	91%	6	9%	2	3%	
CHISAGO								
MA eligible	5	2	40%	3	60%	2	40%	8
180-Day eligible	13	2	15%	11	85%	9	69%	
TOTAL	19	4	21%	14	74%	11	58%	
ISANTI								
MA eligible	5	2	40%	3	60%	2	40%	9
180-Day eligible	27	9	33%	18	67%	6	22%	
TOTAL	32	11	34%	21	66%	8	25%	
KANABEC								
MA eligible	9	3	33%	6	67%	1	11%	10
180-Day eligible	12	2	17%	10	83%	5	42%	
TOTAL	22	5	23%	17	77%	6	27%	
MILLE LACS								
MA eligible	12	2	17%	10	83%	8	67%	9
180-Day eligible	18	4	22%	14	78%	12	67%	
TOTAL	30	6	20%	24	80%	20	67%	
PINE								
MA eligible	5	1	20%	4	80%	4	80%	6
180-Day eligible	19	12	63%	7	37%	5	26%	
TOTAL	26	14	54%	11	42%	9	35%	
SHERBURN								
MA eligible	2	2	100%	0	0%	0	0%	6
180-Day eligible	19	12	63%	7	37%	5	26%	
TOTAL	24	16	67%	7	29%	5	21%	
STEARNS								
MA eligible	38	11	29%	27	71%	22	58%	37
180-Day eligible	182	85	47%	97	53%	48	26%	
TOTAL	223	97	43%	126	57%	70	31%	
WRIGHT								
MA eligible	27	14	52%	13	48%	5	19%	11
180-Day eligible	26	12	46%	14	54%	8	31%	
TOTAL	58	27	47%	30	52%	13	22%	
REGION SEVEN TOTAL								
MA eligible	119	53	45%	66	55%	44	37%	101
180-Day eligible	370	186	50%	184	50%	100	27%	
TOTAL	504	244	48%	256	51%	144	29%	

TABLE B-2I. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION EIGHT								
COTTONWOOD								
MA eligible	2	2	100%	0	0%	0	0%	4
180-Day eligible	5	5	100%	0	0%	0	0%	
TOTAL	8	7	88%	0	0%	0	0%	
JACKSON								
MA eligible	9	7	78%	2	22%	1	11%	6
180-Day eligible	5	1	20%	4	80%	4	80%	
TOTAL	14	8	57%	6	43%	5	36%	
LINCOLN-LYON-MURRAY								
MA eligible	33	14	42%	16	48%	11	33%	17
180-Day eligible	16	9	56%	3	19%	2	13%	
TOTAL	42	24	57%	19	45%	13	31%	
NOBLES								
MA eligible	22	7	32%	15	68%	10	45%	10
180-Day eligible	22	11	50%	11	50%	9	41%	
TOTAL	45	18	40%	27	60%	19	42%	
PIPESTONE								
MA eligible	15	5	33%	8	53%	6	40%	9
180-Day eligible	13	6	46%	9	69%	7	54%	
TOTAL	32	13	41%	19	59%	13	41%	
REDWOOD								
MA eligible	4	1	25%	3	75%	0	0%	6
180-Day eligible	8	4	50%	4	50%	3	38%	
TOTAL	14	6	43%	8	57%	3	21%	
ROCK								
MA eligible	5	4	80%	1	20%	1	20%	6
180-Day eligible	6	4	67%	2	33%	1	17%	
TOTAL	14	8	57%	4	29%	2	14%	
REGION EIGHT TOTAL								
MA eligible	90	40	44%	45	50%	29	32%	58
180-Day eligible	75	40	53%	33	44%	26	35%	
TOTAL	169	84	50%	83	49%	55	33%	

TABLE B-2J. PREADMISSION SCRTEEING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION NINE								
BLUE EARTH								
MA eligible	30	16	53%	14	47%	12	40%	19
180-Day eligible	69	45	65%	24	35%	21	30%	
TOTAL	101	62	61%	38	38%	33	33%	
BROWN								
MA eligible	6	4	67%	2	33%	2	33%	6
180-Day eligible	12	5	42%	7	58%	5	42%	
TOTAL	20	9	45%	11	55%	7	35%	
FARIBAULT-MARTIN-WATONWAN								
MA eligible	16	4	25%	12	75%	7	44%	17
180-Day eligible	23	7	30%	16	70%	6	26%	
TOTAL	40	12	30%	28	70%	13	33%	
LE SUEUR								
MA eligible	9	3	33%	6	67%	3	33%	9
180-Day eligible	12	7	58%	5	42%	2	17%	
TOTAL	23	11	48%	12	52%	6	26%	
NICOLLET								
MA eligible	3	0	0%	3	100%	3	100%	6
180-Day eligible	4	2	50%	2	50%	1	25%	
TOTAL	8	2	25%	5	63%	4	50%	
SIBLEY								
MA eligible	5	1	20%	4	80%	1	20%	8
180-Day eligible	22	13	59%	9	41%	7	32%	
TOTAL	30	15	50%	15	50%	8	27%	
WASECA								
MA eligible	11	4	36%	7	64%	7	64%	9
180-Day eligible	14	10	71%	4	29%	3	21%	
TOTAL	26	14	54%	11	42%	10	38%	
REGION NINE TOTAL								
MA eligible	80	32	40%	48	60%	35	44%	74
180-Day eligible	156	89	57%	67	43%	45	29%	
TOTAL	248	125	50%	120	48%	81	33%	

TABLE B-2K. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION TEN								
DODGE								
MA eligible	5	4	80%	1	20%	0	0%	11
180-Day eligible	14	6	43%	9	64%	3	21%	
TOTAL	26	10	38%	16	62%	3	12%	
FILLMORE								
MA eligible	21	6	29%	15	71%	11	52%	14
180-Day eligible	19	4	21%	15	79%	11	58%	
TOTAL	47	13	28%	34	72%	23	49%	
FREEBORN								
MA eligible	11	4	36%	7	64%	6	55%	5
180-Day eligible	18	8	44%	7	39%	4	22%	
TOTAL	27	12	44%	15	56%	11	41%	
GOODHUE								
MA eligible	11	0	0%	11	100%	6	55%	15
180-Day eligible	32	8	25%	24	75%	15	47%	
TOTAL	44	9	20%	35	80%	21	48%	
HOUSTON								
MA eligible	13	9	69%	4	31%	4	31%	9
180-Day eligible	15	1	7%	14	93%	7	47%	
TOTAL	30	10	33%	19	63%	11	37%	
MOWER								
MA eligible	14	10	71%	4	29%	4	29%	16
180-Day eligible	66	19	29%	47	71%	42	64%	
TOTAL	92	30	33%	62	67%	47	51%	
OLMSTED								
MA eligible	20	4	20%	16	80%	12	60%	20
180-Day eligible	74	18	24%	56	76%	42	57%	
TOTAL	97	22	23%	75	77%	54	56%	
RICE								
MA eligible	14	2	14%	12	86%	11	79%	14
180-Day eligible	54	8	15%	46	85%	41	76%	
TOTAL	68	10	15%	58	85%	52	76%	
STEELE								
MA eligible	10	4	40%	6	60%	5	50%	8
180-Day eligible	18	11	61%	7	39%	5	28%	
TOTAL	30	16	53%	13	43%	10	33%	
WABASHA								
MA eligible	15	4	27%	11	73%	10	67%	9
180-Day eligible	10	3	30%	7	70%	7	70%	
TOTAL	25	7	28%	18	72%	17	68%	
WINONA								
MA eligible	23	18	78%	5	22%	5	22%	22
180-Day eligible	66	16	24%	40	61%	35	53%	
TOTAL	94	44	47%	50	53%	41	44%	
REGION TEN TOTAL								
MA eligible	157	65	41%	92	59%	74	47%	143
180-Day eligible	386	102	26%	272	70%	212	55%	
TOTAL	580	183	32%	395	68%	290	50%	

TABLE B-2L. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
STATE FISCAL YEAR 1984 (July 1983 to June 1984)

Area	Total Screened	Placed in Nursing Home		Placed in Community		Placed on ACG		SFY85 MA Cap
REGION ELEVEN								
ANOKA								
MA eligible	17	10	59%	7	41%	4	24%	11
180-Day eligible	55	28	51%	27	49%	16	29%	
TOTAL	78	41	53%	37	47%	20	26%	
CARVER								
MA eligible	12	1	8%	11	92%	10	83%	22
180-Day eligible	53	11	21%	42	79%	32	60%	
TOTAL	77	15	19%	61	79%	42	55%	
DAKOTA								
MA eligible	11	7	64%	4	36%	3	27%	7
180-Day eligible	47	23	49%	24	51%	14	30%	
TOTAL	61	31	51%	29	48%	17	28%	
HENNEPIN								
MA eligible	222	60	27%	162	73%	113	51%	146
180-Day eligible	640	217	34%	423	66%	317	50%	
TOTAL	973	320	33%	651	67%	431	44%	
RAMSEY								
MA eligible	153	28	18%	125	82%	103	67%	186
180-Day eligible	587	98	17%	489	83%	398	68%	
TOTAL	779	130	17%	649	83%	503	65%	
SCOTT								
MA eligible	10	2	20%	8	80%	6	60%	6
180-Day eligible	20	9	45%	11	55%	6	30%	
TOTAL	33	11	33%	22	67%	12	36%	
WASHINGTON								
MA eligible	11	3	27%	8	73%	5	45%	17
180-Day eligible	45	18	40%	27	60%	18	40%	
TOTAL	71	21	30%	50	70%	23	32%	
REGION ELEVEN TOTAL								
MA eligible	436	111	25%	325	75%	244	56%	395
180-Day eligible	1447	404	28%	1043	72%	801	55%	
TOTAL	2072	569	27%	1499	72%	1048	51%	

TABLE B-3A. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY BY EACH QUARTER OF STATE FISCAL YEAR 1984

Area	Total Screened				Placed in Nursing Home				Placed on ACG Program in Community				SFY85 ACG MA-Cap
	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	4th	
REGION ONE TOTAL													
MA eligible	12	22	10	12	7	7	4	4	1	13	4	4	56
180-Day eligible	33	23	25	24	14	13	10	6	13	7	14	12	
TOTAL	51	47	35	40	23	20	14	10	14	20	18	16	
REGION TWO TOTAL													
MA eligible	10	11	9	19	7	5	3	4	5	5	5	7	40
180-Day eligible	11	14	19	18	3	3	7	6	8	7	9	10	
TOTAL	22	25	29	40	9	8	10	11	13	12	14	19	
REGION THREE TOTAL													
MA eligible	36	25	41	40	18	13	17	20	11	9	19	15	97
180-Day eligible	73	71	81	90	37	28	33	40	18	35	30	35	
TOTAL	117	105	134	140	61	45	58	70	30	46	49	49	
REGION FOUR TOTAL													
MA eligible	25	22	22	19	16	11	10	6	6	6	7	8	73
180-Day eligible	39	50	46	45	26	25	22	23	7	18	18	15	
TOTAL	64	67	77	69	42	39	33	30	13	24	28	24	
REGION FIVE TOTAL													
MA eligible	26	16	13	51	18	11	8	23	4	6	1	21	59
180-Day eligible	60	62	49	72	30	34	26	23	19	11	13	31	
TOTAL	86	78	63	124	48	45	34	45	19	17	15	53	
REGION SIX TOTAL													
MA eligible	16	13	25	21	6	7	10	4	7	5	10	13	83
180-Day eligible	46	37	41	35	23	6	12	12	17	26	24	18	
TOTAL	65	56	69	61	30	17	22	18	24	31	34	32	
REGION SEVEN TOTAL													
MA eligible	20	27	33	35	6	12	13	21	9	10	16	9	101
180-Day eligible	89	85	95	97	43	51	51	40	25	18	30	26	
TOTAL	116	115	129	136	51	64	65	62	34	28	46	35	
REGION EIGHT TOTAL													
MA eligible	9	25	24	18	5	13	11	10	1	12	7	5	58
180-Day eligible	4	23	24	17	3	8	16	10	1	10	7	7	
TOTAL	17	49	53	38	9	22	27	22	2	22	16	12	
REGION NINE TOTAL													
MA eligible	22	22	16	19	7	8	5	11	11	9	8	7	74
180-Day eligible	50	36	25	41	32	21	12	22	12	10	10	11	
TOTAL	78	59	43	63	42	30	17	33	24	19	18	18	
REGION TEN TOTAL													
MA eligible	38	28	38	49	15	10	13	20	15	17	19	23	143
180-Day eligible	105	79	84	99	27	27	24	31	57	43	48	60	
TOTAL	153	111	132	161	43	37	37	55	73	60	68	85	
REGION ELEVEN TOTAL													
MA eligible	87	83	132	127	29	21	24	35	44	43	91	61	395
180-Day eligible	320	294	379	434	90	88	98	121	174	158	206	252	
TOTAL	450	410	550	630	129	120	133	175	220	203	291	313	
STATE TOTAL													
MA eligible	301	294	363	410	134	118	118	158	114	135	187	173	1179
180-Day eligible	830	774	868	972	328	304	311	334	351	343	409	477	
TOTAL	1219	1122	1314	1502	487	447	450	531	466	482	597	656	

TABLE B-3B. PREADMISSION SCREENING/ALTERNATIVE CARE GRANT ACTIVITY
PLACEMENTS BY EACH QUARTER OF FISCAL YEAR 1984

Area	PLACEMENT RATES IN EACH QUARTER							
	1st		2nd		3rd		4th	
	NH	ACG	NH	ACG	NH	ACG	NH	ACG
REGION ONE TOTAL								
MA eligible	58.33%	8.33%	31.82%	59.09%	40.00%	40.00%	33.33%	33.33%
180-Day eligible	42.42%	39.39%	56.52%	30.43%	40.00%	56.00%	25.00%	50.00%
TOTAL	45.10%	27.45%	42.55%	42.55%	40.00%	51.43%	25.00%	40.00%
REGION TWO TOTAL								
MA eligible	70.00%	50.00%	45.45%	45.45%	33.33%	55.56%	21.05%	36.84%
180-Day eligible	27.27%	72.73%	21.43%	50.00%	36.84%	47.37%	33.33%	55.56%
TOTAL	40.91%	59.09%	32.00%	48.00%	34.48%	48.28%	27.50%	47.50%
REGION THREE TOTAL								
MA eligible	50.00%	30.56%	52.00%	36.00%	41.46%	46.34%	50.00%	37.50%
180-Day eligible	50.68%	24.66%	39.44%	49.30%	40.74%	37.04%	44.44%	38.89%
TOTAL	52.14%	25.64%	42.86%	43.81%	43.28%	36.57%	50.00%	35.00%
REGION FOUR TOTAL								
MA eligible	64.00%	24.00%	50.00%	27.27%	45.45%	31.82%	31.58%	42.11%
180-Day eligible	66.67%	17.95%	50.00%	36.00%	47.83%	39.13%	51.11%	33.33%
TOTAL	65.63%	20.31%	58.21%	35.82%	42.86%	36.36%	43.48%	34.78%
REGION FIVE TOTAL								
MA eligible	69.23%	15.38%	68.75%	37.50%	61.54%	7.69%	45.10%	41.18%
180-Day eligible	50.00%	31.67%	54.84%	17.74%	53.06%	26.53%	31.94%	43.06%
TOTAL	55.81%	22.09%	57.69%	21.79%	53.97%	23.81%	36.29%	42.74%
REGION SIX TOTAL								
MA eligible	37.50%	43.75%	53.85%	38.46%	40.00%	40.00%	19.05%	61.90%
180-Day eligible	50.00%	36.96%	16.22%	70.27%	29.27%	58.54%	34.29%	51.43%
TOTAL	46.15%	36.92%	30.36%	55.36%	31.88%	49.28%	29.51%	52.46%
REGION SEVEN TOTAL								
MA eligible	30.00%	45.00%	44.44%	37.04%	39.39%	48.48%	60.00%	25.71%
180-Day eligible	48.31%	28.09%	60.00%	21.18%	53.68%	31.58%	41.24%	26.80%
TOTAL	43.97%	29.31%	55.65%	24.35%	50.39%	35.66%	45.59%	25.74%
REGION EIGHT TOTAL								
MA eligible	55.56%	11.11%	52.00%	48.00%	45.83%	29.17%	55.56%	27.78%
180-Day eligible	75.00%	25.00%	34.78%	43.48%	66.67%	29.17%	58.82%	41.18%
TOTAL	52.94%	11.76%	44.90%	44.90%	50.94%	30.19%	57.89%	31.58%
REGION NINE TOTAL								
MA eligible	31.82%	50.00%	36.36%	40.91%	31.25%	50.00%	57.89%	36.84%
180-Day eligible	64.00%	24.00%	58.33%	27.78%	48.00%	40.00%	53.66%	26.83%
TOTAL	53.85%	30.77%	50.85%	32.20%	39.53%	41.86%	52.38%	28.57%
REGION TEN TOTAL								
MA eligible	39.47%	39.47%	35.71%	60.71%	34.21%	50.00%	40.82%	46.94%
180-Day eligible	25.71%	54.29%	34.18%	54.43%	28.57%	57.14%	31.31%	60.61%
TOTAL	28.10%	47.71%	33.33%	54.05%	28.03%	51.52%	34.16%	52.80%
REGION ELEVEN TOTAL								
MA eligible	33.33%	50.57%	25.30%	51.81%	18.18%	68.94%	27.56%	48.03%
180-Day eligible	28.13%	54.38%	29.93%	53.74%	25.86%	54.35%	27.88%	58.06%
TOTAL	28.67%	48.89%	29.27%	49.51%	24.18%	52.91%	27.78%	49.68%
STATE TOTAL								
MA eligible	44.52%	37.87%	40.14%	45.92%	32.51%	51.52%	38.54%	42.20%
180-Day eligible	39.52%	42.29%	39.28%	44.32%	35.83%	47.12%	34.36%	49.07%
TOTAL	39.95%	38.23%	39.84%	42.96%	34.25%	45.43%	35.35%	43.68%

4. Department of Human Services (cont.)

Name of Program: ALTERNATIVE CARE GRANTS (ACG)

Purpose: To supplement, not supplant, other funding sources to pay for services to enable elderly persons to remain in the community.

Services Funded by ACG: Adult day care, case management, adult foster care, homemaker, home health aide, respite care, and personal care. Equipment and supplies needed to maintain the elderly person in the home may also be purchased with prior approval. Family members may also be paid to provide personal care under certain circumstances when they can demonstrate financial hardship.

Who is Eligible for ACG Funds: Persons who are 65 years or older, MA eligible or wuld be within 180 days of admission to a certified facility, and are at high risk of nursing home placement,as determined by the county screening team.

Funding Sources: For MA-eligible persons the ACG is funded according to regular MA reimbursement rates (50.3% federal, 44.73% state, and 4.97% county). For 180-day eligible persons the state share is 90% and the county share is 10% of the ACG. There is no cost to MA-eligible persons for ACG services; counties may require 180-day eligible persons to pay based on a sliding scale fee.

ACG significant program characteristics:
1) Mandatory county participation since July 1,1983; 2) In SFY84, once an MA eligible person receives services through ACG they may count against an 1179 federal cap on program participants, and cannot be replaced by another person. These "slots" are allocated to counties according to their history of placement in the community for 7/83 - 12/83. Eligible MA clients over county allocations will be funded 90% state, 10% county; 3) Per capita expenditures are also limited under the federal waiver to $3427 per client per year; 4) Homemaker, home health aide, and case management are the most prevalent services provided; 5) Adult day care and respite care are fastest growing services; 6) $3,095,000 of $4,200,000 SFY84 appropriation was spent. $6 million appropriated for ACG services in SFY85. See Tables B-4 and B-5, and Figure B-2.

TABLE B-4. STATEWIDE ALTERNATIVE CARE GRANT ACTIVITY
JULY 1983 TO JUNE 1984

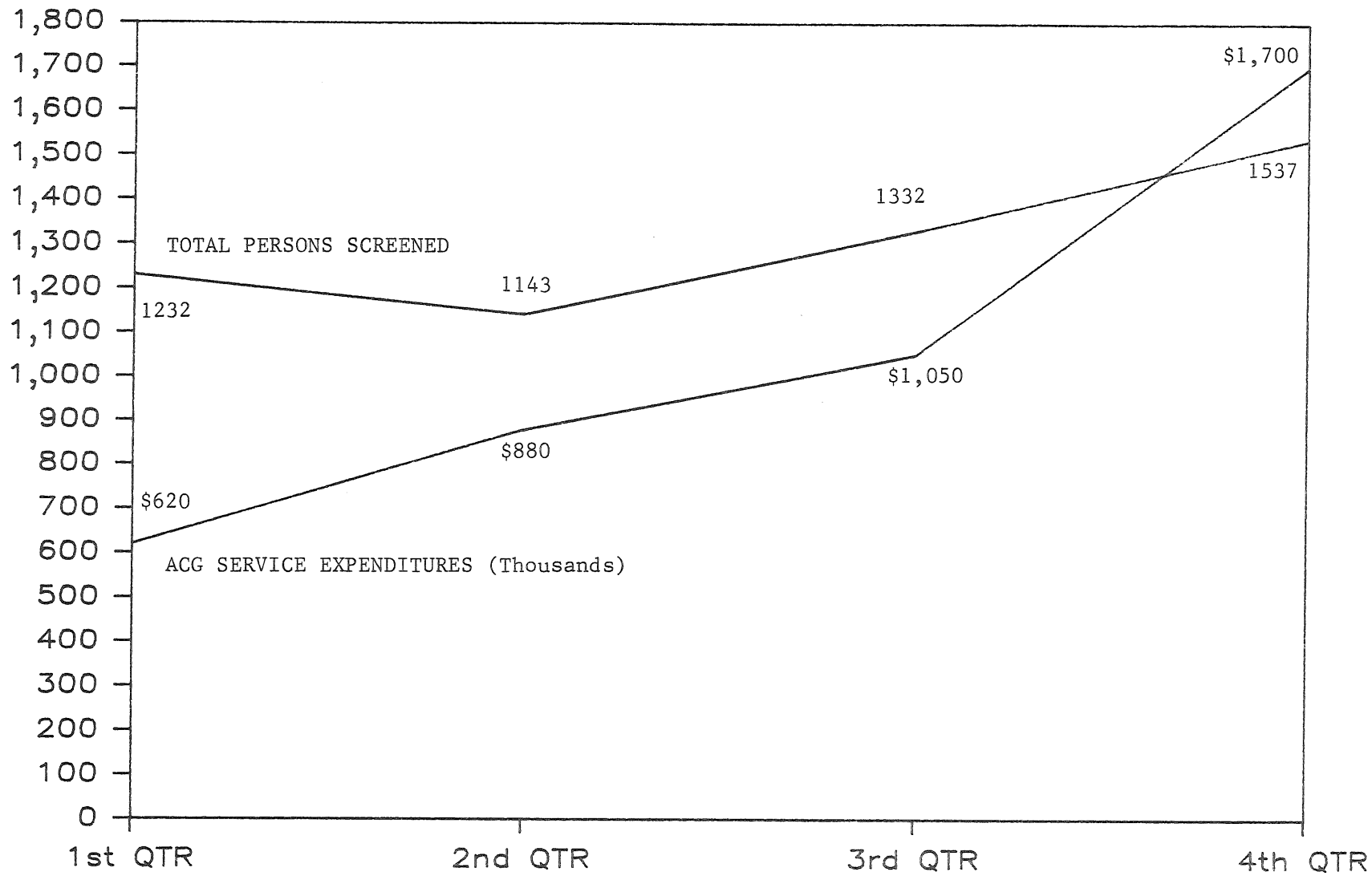
SERVICE	7/83-9/83 persons	service costs per person	10/83-12/83 persons	service costs per person	1/84-3/84 persons	service costs per person	4/84-6/84 persons	service costs per person
ADULT DAY CARE								
MA	40	423.96	50	516.55	62	522.16	70	738.06
180-Day	48	346.15	69	347.74	91	339.78	118	505.88
total	88	381.52	119	418.67	153	413.69	188	592.33
RESPITE CARE								
MA	9	897.52	16	625.64	25	447.36	34	706.82
180-Day	26	423.75	43	517.79	41	393.25	63	685.31
total	35	545.58	59	547.04	66	413.75	97	692.85
HOMEMAKER								
MA	265	435.90	347	423.83	416	418.70	501	560.62
180-Day	241	384.86	402	355.02	438	399.57	523	471.33
total	506	411.59	749	386.90	854	408.89	1023	515.52
HOME HEALTH AIDE								
MA	132	501.02	184	501.79	242	441.89	329	695.52
180-Day	175	442.45	271	622.59	348	512.53	555	627.27
total	307	467.64	455	573.74	590	483.56	884	652.67
ADULT FOSTER CARE								
MA	2	137.32	3	506.83	5	156.59	21	51.19
180-Day	0	--	1	296.70	8	160.58	4	446.56
total	2	137.32	4	454.30	13	159.05	25	114.45
PERSONAL CARE								
MA	40	278.74	48	394.55	52	504.34	65	500.83
180-Day	22	782.25	16	1514.95	60	716.32	86	757.55
total	62	457.40	64	674.65	112	617.90	151	647.04
CASE MANAGEMENT								
MA	210	114.10	272	103.74	345	106.35	391	121.16
180-Day	272	116.33	413	98.07	530	119.19	616	126.12
total	482	115.36	685	100.32	875	114.13	1007	124.19
SUBTOTALS *								
MA	698	346.80	920	352.08	1147	338.60	1411	472.28
180-Day	784	314.62	1215	347.93	1516	334.99	1965	428.57
total	1482	329.78	2135	349.72	2663	336.55	3375	446.97

* Duplicated count.

TABLE B-5. STATEWIDE ALTERNATIVE CARE GRANT ACTIVITY
JULY 1983 TO JUNE 1984

Service	Expenditures 1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	Year
adult day care					
MA	16958.42	25827.55	32374.11	51664.37	126824.45
180-Day	16615.41	23993.78	30919.77	59693.45	131222.41
total	33573.83	49821.33	63293.88	111357.82	258046.86
respite care					
MA	8077.71	10010.28	11183.95	24031.89	53303.83
180-Day	11017.62	22265.00	16123.30	43174.68	92580.60
total	19095.33	32275.28	27307.25	67206.57	145884.43
homemaker					
MA	115512.31	147067.85	174178.17	280870.53	717628.86
180-Day	92750.62	142717.54	175010.55	246507.04	656985.75
total	208262.93	289785.39	349188.72	527377.57	1374614.61
home health aide					
MA	66135.15	92330.21	106937.06	228825.85	494228.27
180-Day	77429.01	168721.97	178361.34	348135.18	772647.50
total	143564.16	261052.18	285298.40	576961.03	1266875.77
adult foster care					
MA	274.64	1520.50	782.94	1075.01	3653.09
180-Day	0.00	296.70	1284.67	1786.23	3367.60
total	274.64	1817.20	2067.61	2861.24	7020.69
personal care					
MA	11149.48	18938.32	26225.72	32554.26	88867.78
180-Day	17209.51	24239.23	42978.99	65149.42	149577.15
total	28358.99	43177.55	69204.71	97703.68	238444.93
case management					
MA	23961.81	28216.47	36689.53	47371.78	136239.59
180-Day	31642.63	40503.01	63172.53	77692.27	213010.44
total	55604.44	68719.48	99862.06	125064.05	349250.03
subtotals					
MA	242069.52	323911.18	388371.48	666393.69	1620745.87
180-Day	246664.80	422737.23	507851.15	842138.27	2019391.45
total	488734.32	746648.41	896222.63	1508531.96	3640137.32
administration	131472.88	133441.07	157084.94	191615.76	613614.65
TOTALS	620207.20	880089.48	1053307.57	1700147.72	4253751.97
TOTAL COST TO STATE					
MA	108277.70	144885.47	173718.56	298077.90	724959.63
180-Day Svcs.	221998.32	380463.51	457066.04	757924.44	1817452.31
Admin.	118325.59	120096.96	141376.45	172454.18	552253.19
ACG Total	448601.61	645445.94	772161.04	1228456.52	3094665.12
PREADMISSION SCREENINGS	110935.00	116435.00	104555.00	162860.00	494785.00
TOTAL PROGRAM COST TO STATE	559536.61	761880.94	876716.04	1391316.52	3589450.12

FIGURE B-2. ACG SERVICE EXPENDITURES AND NUMBER OF SCREENINGS INCREASE THROUGH SFY84



4. Department of Human Services (cont.)

Name of Program: TITLE III OLDER AMERICANS ACT

Purpose and Objectives: To provide services that promote independent and fulfilling lives for persons age 60+ through community based agencies. Emphasis on reducing isolation and preventing untimely or unnecessary institutionalization. Funds also provided to regional area agencies on aging to give technical assistance to local agencies.

Funding Sources: (millions of dollars)	SFY81	SFY82	SFY83	SFY84	SFY85
Local	1.8	1.8	1.6	1.6	1.6
State	3.1	3.3	1.6	3.5	3.5
Federal	12.9	12.7	11.6	11.6	11.6
Other	2.8	3.0	2.8	2.9	3.0
Totals	20.6	20.7	17.6	19.6	19.7

Eligibility Requirements: Area agencies on aging submit three year plan with annual update. Services are targeted to persons age 60+ based on economic or social need; federal law prohibits the use of needs tests for determining eligibility.

Administration and Planning: Minnesota Board on Aging approves local plans, supervises local program administration, and distributes funds according to a federally approved formula: 1) $50,000 to each of 15 area agencies on aging; 2) 70 percent based on elderly populalation; 3) 25 percent based on low income elderly; and 4) 5 percent based on minority elderly.

Services: Part III B. social services: 1) access services (transportation, information and referral); 2) in home services (homemaker, reassurance); and 3) legal aid. Part III C. nutrition services: C1. home delivered meals; C2. congregate meals.

Persons Served: In calendar 1983 over 3 million meals were served; in 1984 Area Agency plans show an estimated 3,442,006 congregate, and 923,884 home delivered meals will be served.

Other Available Data: See Table B-6.

TABLE B-6. 1983 TITLE III. PROGRAM SUMMARY (ACTUAL EXPENDITURES), AND 1984 TITLE III. PROGRAM PLANS (TITLE III. FUNDS ONLY)

(funds in thousands of dollars)

Service	nonlocal funds 1983	nonlocal funds 1984	local funds 1983	project income 1983	# of projects 1983	# of projects 1984	persons served 1983	persons served 1984
Congregate* Meals	$8,316	$6,290	$1,237	$2,855	20	21	85,011	92,890
Home Del.** Meals	1,448	964	249	912	30	29	9,077	7,653
Legal Svcs.	585	579	450	11	18	17	10,261	16,627
Transportation	513	671	412	122	30	27	14,060	15,349
Homemaker	319	430	287	85	20	22	1,362	2,117
Home Hlth Aide	427	393	279	71	26	23	1,401	1,739
Chore	501	460	329	76	18	16	4,658	4,577
Adult Day Care	251	226	192	123	10	9	359	386
Assessment	89	81	52	4	5	5	2,066	2,575
Health Care	14	23	6	2	2	2	66	252
Housing Ass't	43	62	38	2	3	4	428	365
Outreach	24	26	19	-	2	3	297	200
Info. & Referral	33	33	16	-	2	2	2,969	2,869
Advocacy	199	194	138	2	17	10	36,574	5,200
Counseling	43	61	14	<1	5	3	520	637
Ombudsman	83	182	45	<1	1	5	1,000	5,172
Case Management	13	11	9	<1	1	1	125	140
Adult Education	21	15	7	<1	3	1	1,108	1,144
Senior Centers	434	333	214	99	28	12+	7,888	10,688
McKnight Senior Ctrs.	166		62	2	29		910	
Subtotals	$13,526	$9,717	$4,055	$4,367	270	234	180,074	170,580
Area Agency on Aging Administration	1,368	1,480	456	70	n/a	n/a	n/a	n/a
Minnesota Board on Aging Administration	560	560	n/a	n/a	n/a	n/a	n/a	n/a
TOTALS	$15,454	11,810	$4,516	$4,437				

* 1983 nonlocal funds include $6,096 from Title III, $1,622,000 in federal USDA meal reimbursement, and $599,000 in state nutrition funds. 1984 nonlocal funds include $4,975,000 in federal Title III funds, and $1,315,000 in state nutrition funds.

** 1983 nonlocal funds include $1,026,000 from Title III, and $423,000 from federal USDA meal reimbursement.

Source: MN Board on Aging

4. Department of Transportation

Name of Program: MASS TRANSIT & SPECIAL PROGRAMS FOR THE HANDICAPPED

Purpose and Objectives: To subsidize the costs of local transit services to the general population, and cost of special transit services for the elderly and handicapped. To provide matching grants to local operators for equipment/capital purchases.

Funding Sources: (millions of dollars)	SFY81	SFY82	SFY83	SFY84	SFY85
Local				44.8	
State	27.0	18.7	24.8	22.1	21.1
Federal				12.2	
Other				40.9	
Totals				120.0	

Eligibility Requirements: Fares; categorical eligibility for elderly and handicapped persons for special transit. Local match varies (see below) for operating expense deficit. Local match for capital expenditures for special elderly and handicapped transit programs is 20 percent.

Administration and Planning: Minnesota Department of Transportation (MnDoT) and federal Urban and Mass Transit Administrtion (UMTA -- regional office in Chicago) distributes funds to local operators on a grant basis for operating expenses. State allocates funds according to a formula detailed below.

Services: Regular transit services to general population; special services to mobility impaired persons (Metro Mobility, Project Mobility, and other private operators).

Persons Served: 70 percent of nonmetro ridership is estimated to be elderly. 60 Percent of rural transit passengers are 65+, 30 percent of small urban transit passengers 65+, according to a MnDoT survey.

Other Available Data: Local operators receive the following fixed share of their operating deficit (revenues minus costs) from MnDoT and UMTA: MTC, 21%; large urban, 45%; small urban, 60%; rural, 65%; private operators, 63%; and Metro Mobility, 100%. 20 percent match required of local operators for federal capital assistance; $3 million is maximum available for capitol support, of which $2 million has been transferred to operating expenses in recent years by local operators.

4. Department of Veterans Affairs

Name of Program: VETERANS HOMES

Purpose and Objectives: To provide health and domicillary care to veterans or spouses or parents of veterans to enable individuals to live at their highest level of functioning.

Funding Sources: (millions of dollars)	SFY81	SFY82	SFY83	SFY84	SFY85
Local					
State	5.88	5.70	7.86	8.49	8.72
Federal	.02	.01			
Other	.02	.02	.90	.57	.59
Totals	5.92	5.73	8.76	9.06	9.31

Eligibility Requirements: Veteran, spouse or parent of veteran.

Administration and Planning: Veterans Affairs administers homes, coordinating with federal Veterans Administration on other available services.

Services: Nursing home and domicillary care. Chemical dependency program located on the Minneapolis capmus; Hastings is the location of the other veterans home.

Persons Served: Approximately 250 nursing home beds and 290 board and care beds in Minneapolis, 200 board and care beds in Hastings.

Other Available Data: Estimated SFY85 nursing perdiem of $50.38, and domicillary per diem of $26.67. For a comprehensive review of long term care programs for veterans see: Final Report: Long-Term Care Services for Veterans, Minnesota Department of Veterans Affairs, 1984.

APPENDIX C.

STATE STATUTORY AND REGULATORY REQUIREMENTS OF LOCAL AGENCIES

COUNTY WELFARE BOARDS (1937)

Membership, Powers, and Duties: A Welfare Board is mandatory for all counties. Board includes three or five county commissioners and two citizens. Multi-county boards allowed. Administers general public welfare programs. Recommends budget to county board which can change and/or approve budget. Hennepin County Board is Hennepin County Welfare Board. Commissioner of Human Services can add programs to the responsibilities of county welfare boards.

Programs and Operations: Programs include child welfare, social security, income assistance, mental health, food stamps, public assistance, and other public welfare services according to state laws and regulations, including a merit system. Must contract with existing community agencies for home health and public health nurses. May charge fees for services or enforce its lien. May form an advisory committee for consultation.

Planning and Reporting: Financial reporting; other reporting as required under federal social security act.

Other Requirements, Issues and Comments: County boards retain the power to budget and levy taxes for funding the operations of the county welfare board. Other programs have their own reporting and operational requirements noted below. (Ref.: MN Stat. 393.)

BOARD ON AGING (1961); AREA AGENCIES ON AGING

Membership, Powers, and Duties: 25 members appointed by the Governor to a maximum of two four-year terms. Board advises governor and state agencies, coordinates plans and activities of public and private agencies, informs and educates people and groups/agencies, reviews programs and legislation, and implements/administers programs, including promulgation of rules and regulations, in the interest of older Minnesotans.

Programs and Operations: Provides grants to local agencies for Older Americans Act funds (Title III and IV), along with grants for senior volunteer, foster grandparent, and senior companion programs. Develops policy and program alternatives for long term care. Advocates for persons eligible to receive services (ombudsman). Provides technical assistance to local grant recipients.

Planning and Reporting: Local grantees provide semiannual reports on program activities according to the requirements of the board. Regional area agencies on aging develop planning information for optional use by local agencies.

Other Requirements, Issues and Comments: Regional body that awards grants to local agencies is not necessarily the same as the area agency on aging (may be regional development commission), with the result that funds and technical assistance come from two different authorities. All local agencies compete for funds available, including local health board, county social service agency, community action agency, and indian tribal council. (Ref.: MN Stat. 256.975.)

HUMAN SERVICES BOARDS (1973)

Membership, Powers, and Duties: One or more counties within a regional development district may form a human services board (HSB), which includes at least one member from each county board andoptional citizen members. HSB must serve at least 30,000 persons. HSB takes on all powers and duties of county health, welfare, and mental health boards. Recommends budget to county board(s) which can change and/or approve budget, and levy taxes.

Programs and Operations: Provides direct or purchased services including corrections, public health, public assistance, mental retardation, mental health, and social services, receiving all funds provided by state agencies for such programs in the HSB service area. Merit personnel system required. HSB must appoint a single director for the agency. Mandatory advisory committee, including permanent task forces for corrections, social services, mental health, and public health services.

Planning and Reporting: Annual plan required in accordance with rules of state planning director, and the commissioner of human services, and approved by the commissioners of health and corrections. Public hearing, citizen and local nongovernment service agency participation required for plan. Each affected state agency shall accept this plan in lieu of other required plans. State agencies may delegate any of its functions to a HSB which has an approved plan for such activities.

Other Requirements, Issues and Comments: HSB annual plans are not currently accepted by state agencies in lieu of other plans. Norules or planning requirements have been promulgated by the agencies. Statute requires state auditor to audit books of HSB, for which HSB pays in addition to its regular county audit. Planning requirements more burdensome than for any other program. Restriction on counties joining to form a HSB within a regional development district do not apply to other multi-county service boards and agencies. (Reference: MN Statutes 402.)

LOCAL HEALTH BOARDS; COMMUNITY HEALTH SERVICES (CHS) (1976)

Membership, Powers, and Duties: One or more counties which include a population of at least 30,000 must form a local health board, which can be a human services board, the county board, or a citizen board including service providers appointed by the county board(s), in order to recieve CHS subsidies. Certain cities may also receive CHS funds. Responsible for all local health activities imposed by the state

Department of Health. Recommends budget to county board(s) which changes/approves budget, and levies taxes.

Programs and Operations: Provides direct or purchased services including home, community, institutional, and environmental health, disease prevention and control, health education and family planning, public health nursing and emergency medical services. Advisory committee mandatory to receive CHS funds.

Planning and Reporting: Biennial plan (6 months after state biennial budget) required addressing development, implementation, coordination, and operation of community health services that meet local priority needs, budget estimates, and evaluation of programs. Regional Development Commission reviews for conformance. Community participation required. Standard reporting only for public health nursing was required previous to 1983; new standard reporting required for all of CHS began in 1983. No funds given without approved plan.

Other Requirements, Issues and Comments: Complicated subsidy (grant) formula is being reworked. Possible changes in planning cycle: conform to state biennial budget (and CSSA planning) cycle; lengthen cycle to include longer range planning and improve ability of the state to provide technical assistance and planning support to local health boards. Reporting standards do not ensure comparability with CSSA reporting. Planning standards do not ensure comparability among local health board plans. (Ref.: MN Stat. 145.911 to 145.922.)

COUNTY SOCIAL SERVICES AGENCIES; COMMUNITY SOCIAL SERVICES ACT (1979)

Membership, Powers, and Duties: CSSA added responsibility for administration and delivery of CSSA services to county boards under the supervision of the commissioner of human services. County boards approve budgets and levy taxes for CSSA programs at least equal to the amount of CSSA grant funds received from the state. Counties within the same regional development district may form an agreement to jointly provide social services; the combined agency may encompass completely two regions.

Programs and Operations: Provides direct and purchased services to target groups identified by the county in its biennial plan, including vulnerable adults and persons age 60+ who are experiencing difficulty living independently. CSSA programs are combined with certain other progras including federal Title XX, Title IV B and E, and other state categorical programs for the purpose of planning, administration and delivery of services.

Planning and Reporting: Biennial plan (6 months before state biennial budget) required addressing target populations to be served, local program goals, identification of needs, resources available, services to be provided by the county, budget estimates, and program evaluation method. Citizen participation required with public notice. Commissioner of human services reduces quarterly grant payment by 1/3 of one percent for each 30 days a county fails to submit an approved plan (4 percent reduction maximum penalty per year). Same reporting

system required for CSSA, Title XX, and other funded services.

Other Requirements, Issues and Comments: See above comments on CHS planning cycle. Also refer to legislative auditor's report on CSSA and CHS block grants noted in Appendix D. (Ref.: MN Stat. 256E.)

COMMUNITY ACTION AGENCIES (1981)

Membership, Powers, and Duties: Community action agencies (CAAs) serve one or more political subdivisions (when designated by those subdivisions), and may be an indian tribal council, a public or private nonprofit agency. CAA boards have 15 to 51 members, 1/3 elected public officials, at least 1/3 democratically selected to represent low income persons, and the rest representing various community interests. Administers programs intended to reduce poverty and its causes. The Minnesota Migrant Council is a CAA.

Programs and Operations: Provides direct and purchased services targeted to low income and minority persons, including Community Services Block Grant, Minnesota Equal Opportunity Grants, energy and weatherization assistance, commodity distribution, and other programs funded by local government or foundations. Advocates for low income persons to ensure fair treatment under various programs, to enable their participation in neighborhood groups, and to enhance their ability to influence the direction of policies and programs.

Planning and Reporting: Statute requires program planning, developing information on problems and causes of poverty, determining effectiveness of local efforts, and establishing priorities for action. Annual report on use of state funds to Commissioner of Economic Security. Consultation required among local institutions, government, and corporations.

Other Requirements, Issues and Comments: Least burdensome with respect to program or agency requirements. (Ref.: MN Stat. 268.52 to 268.54.)

APPENDIX D.

SELECTED REFERENCES

Citizens League

- A Farewell to Welfare, February 1984
- Meeting the Crisis in Institutional Care, April 1984

Health Futures Institute

- The Preadmission Screening and Alternative Care Grant Program: A Description and Analysis of Minnesota's Experience, 1984

Metropolitan Council Area Agency on Aging

- Plan for the Service Delivery System in Anoka County, 1984
- Plan for the Service Delivery System in Dakota County, 1981
- Plan for the Service Delivery System in Hennepin County, 1982
- Plan for the Service Delivery System in Ramsey County, 1979
- More than Shelter: Housing and Services Plan for Older People, 1984

Minnesota Department of Health

- Recommendations for the Improvement of Home Health Services in Minnesota, a report of the Home Health Task Force to the Commissioner of Health, July 1984
- Minnesota Long Term Care Plan, Office of Community Development, October 1981
- The Long Term Care System, Local Management -- A Minnesota Model, Office of Community Development, February 1983
- Long Term Care: A Compilation of Issues, Trends, and Recommendations, 1976 - 1982, Office of Community Development, August 1982
- (CHS annual)

Minnesota Department of Human Services

- Cost Containment Study: Home Care, 1978
- Social Services in Minnesota: Services Provided and Expenditures under the Community Social Services Act in 1982, 1983 (annual)

Minnesota Department of Veterans Affairs

- Final Report, Interagency Task Force on Long Term Care for Veterans, August 1984

Minnesota State Demographer

- Minnesota Population Projections 1980 - 2010, May 1983
- Population Notes, "Nursing Home Growth in 1970s Largely Due to Increase in Population 85 years and over," December 1983

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Minnesota State Planning Agency

- Minnesota's Elderly in the 1990s, (series) 1981

  Final Report
  The Changing Minnesota Elderly: A Demographic Report
  The Economic Status of Minnesota's Elderly
  The Elderly as a Resource: An Examination of Volunteerism Among Minnesota's Elderly
  Health and Long Term Care for the Elderly
  Housing for the Elderly
  Tax Policy and the Elderly
  Energy Policy and the Elderly